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ABSTRACT

This document presents witnesses' testimonies and prepared statements from the Congressional hearing called to examine the issue of equal access to health care and the practice of patient dumping which may take the form of transferring a patient to another hospital, refusing to treat a patient, or subjecting a patient to long delays, and which may involve discrimination on the basis of poverty, race, ethnicity, or appearance. Opening statements are included from Representatives Ted Weiss and Jim Lightfoot. Witnesses providing testimony include: (1) Fortney Stark, Congressional Representative from California; (2) Zettie Mae Hill and Jesse Green, who tell of their personal experiences with patient dumping; (3) Judith Waxman, managing attorney, National Health Law Program; (4) Arnold Relman, editor, New England Journal of Medicine; (5) Arthur Kellermann, medical director, Emergency Services, the Regional Medical Center, Memphis, Tennessee; (6) David Ansell, attending physician, Division of General Medicine/Primary Care, Cook County Hospital, Chicago, Illinois; and (7) William Roper, administrator, Health Care Financing Administration (HCFA), United States Department of Health and Human Services, accompanied by Richard Kusserow, inspector general, and Audrey Morton, director, Office for Civil Rights. HCFA witnesses reported on federal efforts to enforce the anti-dumping laws. Additional testimony/statement were submitted by the Coalition To Stop Patient Dumping, the American College of Emergency Physicians, and Legal Services of Tennessee. The appendixes include legislative and regulatory materials. (NB)

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ED297237

EQUAL ACCESS TO HEALTH CARE: PATIENT DUMPING

HEARING

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON

GOVERNMENT OPERATIONS

HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

JULY 22, 1987

Printed for the use of the Committee on Government Operations

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EQUAL ACCESS TO HEALTH CARE: PATIENT DUMPING

WEDNESDAY, JULY 22, 1987

House of Representatives,
Human Resources and
Intergovernmental Relations Subcommittee
of the Committee on Government Operations,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:35 a.m., in room 2247, Rayburn House Office Building, Hon. Ted Weiss (chairman of the subcommittee) presiding.

Present: Representatives Ted Weiss, Thomas C. Sawyer, Jim Lightfoot, and Ernest L. Konnyu.

Also present: Representative Nancy Pelosi.

Staff present: James R. Gottlieb, staff director; Patricia S. Fleming, professional staff member; Pamela H. Welch, clerk; and Mary Kazmerzak, minority professional staff, Committee on Government Operations.

OPENING STATEMENT OF CHAIRMAN WEISS

Mr. Weiss. Good morning. The Subcommittee on Human Resources and Intergovernmental Relations will come to order.

I am going to start today's hearing a little differently. I want to tell you about an incident that actually occurred recently in California, but could have happened anywhere.

A pregnant woman, whose labor pains have begun, knows she is about to give birth. She goes to the emergency room of a nearby private hospital. The emergency intake staff interview her and ask her about her ability to pay and her insurance status.

She is uninsured and has no means to pay the hospital for delivering her baby. Preliminary tests that might have shown that her baby is in trouble are not done. The hospital staff refuse to admit her, and she has no way of knowing her baby is having difficulty.

After waiting 3 hours in the emergency room, in active labor, she prevails upon the hospital staff to send her by ambulance to the nearest public hospital. After she arrives at the public hospital, her baby is born, but it is dead. According to the physician in the public hospital, had she received prompt attention, her baby's life could have been saved.

Stories like this one, of sick or injured people, people who are refused treatment at hospital emergency rooms because of their inability to pay, occur with alarming frequency in all parts of this country. Patient dumping can take many forms. The most common is for economic reasons. It can be carried out by transferring a patient to another hospital, refusing to treat them, or subjecting them to long delays before the patient finally leaves.

Dumping may involve discrimination on the basis of poverty, race, ethnicity or appearance. Dumping can result from hospital policies and practices that include requiring advance payment, refusing to accept Medicaid, refusing to treat persons who do not have a personal physician on staff, and refusal to treat patients with undesirable conditions such as intoxication or overdose symptoms.

The transfer of patients from one hospital emergency room to another is a common practice. During the past 5 years, patient transfers have increased markedly, as have the number of people without insurance. In 1977, there were 25 million uninsured Americans. Today, there are 35 million. Studies show that the dumped patients are disproportionately poor, black, Hispanic, and native American. A large percentage are the working poor. Dumping of people suspected of being infected with the AIDS virus is on the rise.

There are at least three Federal laws governing inappropriate patient transfers. Legislation was enacted last year under the leadership of Congressman Pete Stark that prohibits the transfer of medically unstable patients.

Additionally, hospitals built with Hill-Burton funds must provide emergency care to certain individuals regardless of ability to pay, and civil rights laws bar discriminatory treatment such as dumping for reasons related to race, national origin or handicap.

This morning we will hear from people who have knowledge of dumping as a personal experience and from a professional perspective. We will also hear testimony from three administration witnesses who will report on Federal efforts to enforce the anti-dumping laws.

At this time, I am pleased to call on our distinguished ranking minority member, Mr. Lightfoot.

Mr. LIGHTFOOT. Thank you, Mr. Chairman. I appreciate your calling this hearing today to examine access to emergency health care services by our Nation's poor and uninsured individuals.

As Chairman Weiss indicated in his opening statement, laws exist which prohibit hospital emergency rooms from refusing to treat individuals with emergency health conditions or transferring unstable individuals to other hospitals.

This practice, known as patient dumping, is a serious problem, and deserves thorough, ongoing consideration in Congress.

One of the laws which prohibits patient dumping was approved by Congress last year, as part of the Consolidated Budget Reconciliation Act, the acronym of which is COBRA, and I think in the places where it bites, that is a pretty good acronym. This new law, effective August 1, 1986, prohibits hospitals from transferring a patient until his or her condition is stabilized, and they have secured approval from the hospital that will receive the patient.

For those hospitals who refuse to comply with this provision, their Medicare provider agreements could be terminated or suspended, and they could face monetary and civil penalties.

The hearing today should give us a better idea of the extent of the problem of patient dumping, and whether current laws are adequate to address the problem. In addition, it is important for this subcommittee to learn more about how the Department of Health and Human Services plans to implement and coordinate the new patient dumping provisions.

Furthermore, it is essential that we review whether HHS has been adequately enforcing the community assurance provisions of the Hill-Burton Act which require hospitals to treat certain individuals with emergency health problems.

Mr. Chairman, I look forward to hearing the testimony from today's witnesses. They should provide us with some good information on whether the current laws are adequate and whether further action is necessary to make sure that poor and uninsured individuals are not denied health care services, particularly during an emergency.

Thank you, Mr. Chairman.

Mr. WEISS. Thank you, very much, Mr. Lightfoot.

Let me indicate before we begin that the House will be going into session at 10 o'clock. From time to time, we may be interrupted for votes. We will attempt to make the breaks as brief as possible and we will move expeditiously. My hope and expectation is that we will be able to complete the hearing in one continuous session, rather than breaking for lunch.

I should also note that from time to time members of the subcommittee will be going to other scheduled appointments and then perhaps returning to us as we go along.

Our first witness is Representative Pete Stark. Pete, welcome.

The legislation that we will be discussing today is authored by Mr. Stark and was adopted by the Congress last year. Mr. Stark is the chairman of the Health Subcommittee of the Ways and Means Committee and is a Member who is most involved with health-related matters through the work of that subcommittee.

We very much appreciate your work and the ability to participate with us. We know that you have important legislation on the floor today, as a matter of fact. You may proceed as you like.

STATEMENT OF HON. FORTNEY H. (PETE) STARK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. STARK. Thank you, Mr. Chairman. I appreciate the work you and your distinguished ranking member are undertaking.

I have a prepared statement, and I would like to submit it for inclusion in the record, if you desire.

Mr. WEISS. Without objection, it will be entered in the record in its entirety.

Mr. STARK. To summarize and perhaps to philosophize with you for a moment or two, you are today going to hear anecdotes which will sound like the worst horror stories you could think of. You are going to hear statistics which will support the fact that these anecdotes are probably not just happenstance or rare instances.

What you will not find, in my opinion, is some concerted effort to deny medical care to people. You will find cases of indifference, I suppose motivated by greed. You will find cases of people just too busy to take the extra time to determine what is needed medically to stabilize somebody before they are transferred, and I am sure you will end up the day somewhat frustrated.

I suspect most of your frustration will come in finding, one, that dumping is a common practice. Dumping occurs for a lot of reasons. Perhaps the emergency room, where most of this takes place, is understaffed. Perhaps they are underpaid. Perhaps the patient, or the person who is injured, is unwilling to speak up to get to the head of the line to make their problems known. They are intimidated by an institution which can be very impersonal.

But it seems to me that all the laws can do and all we can do is put some incentive, and indeed some penalty, for people who do the obvious thing. We are not phvsicians. We are not competent to judge what are proper medical procedures, but it does seem to me that when physicians can agree that uncommon indifference just resulted in death or compounded the seriousness of a injury, we have to penalize it.

We did enact last year an antidumping provision and it established some guidelines. I think that perhaps everybody but the AMA thought it was a good idea. We thought the penalties ought to be a little more severe. We like the idea of criminal penalties, but we are not lawyers. It always seems to me just so simple; if somebody disobeys the law, a $50 fine isn't going to bother them much if they are making $100,000 a year.

Six months in the slammer probably would get their attention and it always seemed to me that the stiffer the penalty, the more people would pay attention. We have a monetary penalty of up to $25,000 and a real stiff penalty is that the hospital can lose its right to practice under Medicare. That, for most hospitals, would be putting them out of business.

Somehow we have not found the middle ground. In a sense, we had a case in Congressman Miller's district in California, neighboring my district. It took this Member of Congress, who has perhaps an unusually close relationship with the Department of Health and Human Services, to even get them to look into a serious question of patient dumping, in which a child died because a woman was not given proper obstetric care. But the problem was that they were going to close the hospital.

There was no real middle ground, and the hospital served an awful lot of indigent people. That hospital was a necessary force in an otherwise underserved community. It hardly seems that invoking that kind of tough penalty was the proper answer.

I think there are probably some revisions needed in our bill. The real problem, and the distinguished gentleman from Iowa will permit a little partisan comment here, is the White House syndrome.

If we don't like the law, we won't enforce it. Whether that happens to be Contras, or detailing employees in over and above a budget that has been approved or, in this case, we just don't have any regulations.

I am not so sure whether that is just an understaffed and overworked Department of Health and Human Services, or whether they just don't like the law and therefore don't want to implement the regulations.

I would hope that this committee, in its deliberations, in its questioning, might find a way to encourage HCFA and Health and Human Services to promulgate regulations and then enforce them. It just boggles my mind that there have only been 33 complaints, with 6,000 hospitals in the United States.

I suspect that there have been more cases out and abroad in the land than 33. People don't know where to go. It is very difficult, if not impossible—there is no 911. There is no place that is generally known by people who have been mistreated, or their families, to go to complain. It just seems to me that we have to start to do something to make the law known and to encourage hospitals to begin to obey it.

Hospitals provided an awful lot of uncompensated care last year, however, I would like to comment on one recent study.

The Robert Wood Johnson Foundation's study of access to medical care, who are objective and scholarly in their approach, found that the number of people who are denied medical care is increasing. I have tried to work out a bill that would provide indigent care assistance to hospitals who provide this care and don't get paid for it.

Basically, the revenue in this bill comes from an excise tax on all employer plans. What that basically says is that the people who are fortunate enough to be in a group health plan, such as yourself, the other Members, myself, people in union-sponsored plans, people in private plans who are executives in companies, all have access to health care, and, in general, those plans provide excellent care.

It seems to me that they should pay a little extra and I want to hasten to point out to you that in a system where there is no free lunch, in spite of the cases of dumping, we generally do provide—last year $7 billion of uncompensated care. Who pays for that? We all do; higher premiums on our own health insurance. Higher costs for a hospital room, the doctors will charge a little higher because they think they are providing charity care, particularly on Wednesday afternoons.

But as a practical matter, we have to spread the cost more fairly and that is what my bill would attempt to do. The State of Florida would suggest doing it by a room tax on hospitals. It seems to me somewhat unfair to tax those who are already sick. They didn't choose to be there; they already have a catastrophe in their own lives; why increase their burden?

Why shouldn't we all, as we are healthy, pay a little bit more, 25 cents a month or something of that order, on our monthly health insurance premiums to provide uncompensated care, or assistance to the hospitals who provide it?

I think this is the way we can go. I think we are not going to go to a national health insurance program. We fought that battle 20 years ago and lost. So I think we are going to have to, in a piecemeal fashion, find those elements, segments, groups in our society who need the most help and somehow find a way to spread the costs fairly.

That is what we will continue in an attempt to do, and I would like to continue to encourage this committee to bring to the public's attention the problems that exist and to ferret out the reasons for some of the slow resolutions of those problems.

I commend you and your members for the work you are doing and hope that we can work together to see health care provided more uniformly across this land.

Thank you, very much.

[The prepared statement of Mr. Stark follows:]

TESTIMONY OF THE HONORABLE FORTNEY H. (PETE) STARK
BEFORE THE
HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
HEARING ON EQUAL ACCESS TO HEALTH CARE: PATIENT DUMPING
WEDNESDAY, JULY 22, 1987

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to testify at these hearings on patient dumping. I welcome your efforts to draw attention to the continuing problems of patient dumping despite firm legislative action last year.

Patient dumping is a disgracefully common practice. Today you will hear from people who have been victimized by this practice and from people who have cared for these ping-pong patients. It is simply not acceptable to kick desperately ill people from one hospital to another because they can't foot the bill.

Last year we enacted the Medicare anti-dumping provision that established guidelines for the safe transfer between hospitals of critically ill patients and women in active labor. Under this provision a hospital must provide stabilizing treatment to any individual with an emergency medical condition or a woman in active labor. Transfer to another hospital can be considered only after stabilization and only if the patient agrees to be transferred.

This provision was enacted into law as a part of COBRA and took effect August 1, 1986.

If a hospital or physician violates the requirements of this provision, they are subject to a civil monetary penalty of up to $25,000 and may be subject to civil action if an individual suffers personal harm. Furthermore, the hospital can lose its Medicare provider agreement. One of the first hospitals investigated under this law was Brookside Hospital, which is located adjacent to my District.

But to date the Department of Health and Human Services has yet to issue regulations for the enforcement of this law. While they continue their irresponsible foot dragging, people continue to suffer and even die.

How a person knows to call some faceless bureaucrat either in their State or in Washington with their complaint is a testament to the human will. HHS has not made it easy for an aggrieved patient or family to register a complaint against a hospital or doctor. I believe that to date the Department has received 33 complaints. With 6000 hospitals in this country and millions of emergency room visits per year, it stretches the limits of imagination to believe that there have only been 33 cases of patient dumping since this law was enacted.

In addition to not issuing regulations, the Department has also failed to report to Congress on the methods used to monitor and enforce compliance with the provisions of the law.

Mr. Chairman, patient dumping is but a single symptom of a much bigger problem: low income sick people are finding it increasingly difficult to get needed medical care and the burden of care is increasingly falling on a few hospitals. Stories abound of the ways hospitals have changed their business practices to accommodate to the financial incentives of competition, prospective payment, and capitation. Dumping is one of the more hideous changes.

The recent Robert Wood Johnson Foundation Study of Access to Care confirmed a distressing decline in access to care over the 4 years since the Foundation's 1982 study. This decline in access was particularly harsh for the poor, minorities, and for the medically uninsured. This is a terrible indictment of our much touted health care system.

On the other hand, in 1985, US hospitals provided $7.4 billion dollars in uncompensated care. Virtually all of that care was given by our public and voluntary not-for-profit hospitals. While public hospitals have about 21% of all hospital beds, they provide 55% of all charity care. In our largest metropolitan areas these public hospitals have only 6% of the beds but provide 22% of the charity care.

Taken together, patient dumping and the huge dollar amounts of uncompensated care clearly indicate that the financial difficulties faced by many hospitals, public and voluntary not-for-profit, has led to a serious access to care problem that must be addressed by Congress.

To address one aspect of the problem of access to care, I plan introduce the "Hospital Indigent Care Assistance Act of 1987", a bill to provide support to hospitals financially distressed because of the burdens of providing care to the poor and uninsured. These are the safety net hospitals that are the backbone of hospital care in this country. While we must make sure that the dumping of *unstabilized* patients is stopped, we must also make sure that the treatment of *stabilized* patients does not bankrupt the nation's charity hospitals.

There are two components to my bill. First, is the revenue provision that establishes the Hospital Indigent Care Trust Fund from an excise tax on all employer provided health insurance benefits. This tax is paid for by the employer on the amount paid for health benefits.

The second part of this bill identifies hospitals stressed because of uncompensated care burdens. These hospitals will receive from the new trust fund a percentage of their uncompensated care costs adjusted to reflect contributions to indigent care by state and local government and to reflect the effectiveness of the State's Medicaid program in reducing hospital uncompensated care. These adjustments will help ensure that all concerned will maintain their efforts to provide support for meeting the costs of hospital charity care.

We are beginning to see the fabric of American health care fray. We must make opportunities to rectify inadequacies and injustices as they become evident, least we loose the benefits realized from Federal initiatives like the Medicare and Medicaid programs.

Mr. Weiss. Thank you very much, Pete. Your opening comments have set the framework for our discussions for the balance of this morning.

We have been joined by our distinguished Member from California, Mr. Konnyu. Do you have any opening comments?

Mr. Konnyu. No, thank you, Mr. Chairman.

Mr. Weiss. Mr. Lightfoot, any questions?

Mr. Lightfoot. I would like to discuss a point because it is something that Congressman Stark alluded to very strongly. I come from a rural part of the country, 27 counties, where every hospital is classified as a rural hospital and an aging population that is roughly 25 to 28 percent over the age of 65. We are running into very severe economic problems trying to keep those hospitals open and viable because of the DRG system, and so on, which does not relate specifically to this particular issue.

But, as you were mentioning, uncompensated health care, the problem we are discussing today, I suspect is pretty much confined to urban areas where you have large concentrations of population, and so on. We are fighting a similar battle in terms of trying to keep these rural facilities open, but for different reasons.

When you put the provision in COBRA about a year ago, did you have any indications that the instances had decreased or increased?

Mr. Stark. The hospitals really don't know about it, if the distinguished gentleman from Iowa would yield.

That is one of the troubles. I think there is nothing that will get the attention of hospitals more quickly than to have one of them lose their Medicare license, or pay a $25,000 fine. To pay that fine in a small hospital in Iowa would be a big event. I am not so sure in Manhattan that $25,000 in those huge institutions, or in San Francisco, or San Jose, doesn't fall between the cracks.

But I think that somehow we have to make people aware that we are not going to tolerate dumping. Somehow there is a schism between the medical community and ourselves, as if we really don't quite understand this, and it is "Father knows best," and we will take care of this, and why are you civilians interfering?

I think the reason we are interfering is because of the stories that you are going to hear today. I suspect they are going to make you want to interfere.

The other area that is very much in need are the remote and rural areas. In our reconciliation bill we were faced with budget cuts, as you are aware. I think we are going to do something to alleviate the problem at both ends of that scale. The suburban hospitals may not fare quite as well, but in a list of priorities, I want to assure that we are doing as much as we think we can in that system of priorities to aid those rural hospitals and these impacted inner city hospitals.

It is not a wonderful bill, but it is just one of those things. When you are cutting money away from a system that is already underfunded, it is no fun. I hope that we have done something that will help those folks in your counties in Iowa.

Mr. Lightfoot. I appreciate hearing that from you because I think one of the errors we make, in terms of Federal policy many times, is we just paint everything with a broad brush and in real life it is not that way, as we are both well aware.

I appreciate that you are cognizant of these problems, and you are going to do your best to work them out. Thank you for the work you have done. I think your cause is very noble.

Mr. STARK. Thank you, very much.

Mr. WEISS. Mr. Konnyu.

Mr. KONNYU. Just one quick question. I think you have indicated, and I would perhaps like to hear you strengthen the notion as to the hospitals being aware of the provisions of COBRA. To your knowledge, if they are aware, what is the level of awareness as to what they are required to do?

Mr. STARK. We had a very serious case in George Miller's district about 6 months ago. A woman who was pregnant was transferred. A physician on our committee staff who is currently practicing was able to listen to the two physicians discuss this situation. The one who transferred the woman and the physician who received her at the second hospital into which she was dumped.

It seemed to him a clear case of malpractice and they just didn't discover that the pregnancy was in trouble, and the child died.

There was a great public outcry in the community about this, but the California group that administers hospital laws for HCFA, was unaware of the law. They said, "Well, there is law but we don't have regulations yet and we are not sure we can really move in this case."

Actually, Dr. Roper, who is head of HCFA, was very quick to respond to my request that they move on it. But it shouldn't take a Member of Congress, particularly one who chairs a committee that may be the committee of jurisdiction to get somebody to move.

I submit that that is a little heavy handed, or inefficient as a way to get this done. Then I found myself in the embarrassing position, and I think Dr. Roper as well, that the only penalty was to close the hospital. Somehow, it seems to me we have to find a way to focus on the physician. I am not sure the hospital was totally at fault. They contracted out their emergency room operation to a group of doctors.

In my humble opinion, they probably should find the doctor who made the decision. If it was a conscious decision to save some money, to take the troublesome case and move it to a county hospital, there should be a severe penalty.

I am not sure when you intrude on professional judgment, as legislators, it is a very tricky area and I tiptoe into it because I am very reluctant to try to practice medicine with a mandate.

Mr. KONNYU. I am sure you agree with respect to each hospital, it is the administrator who has to drive that home to the doctors.

Mr. STARK. The gentleman is absolutely correct. We have to start at the top and make HCFA know that we won't tolerate dumping, and if the laws are not adequate, come back to us and tell us how to change them. We would pass that on a bipartisan basis through the House so fast it would make your head spin.

If HCFA came to us and said, "We want to stop dumping and we need these laws changed to help us enforce it," I can believe there wouldn't be a vote against it on the floor. I am saying it starts here, and it has to go up or down the line, whichever way you want, and then the hospitals have to know that we mean business. We provide, just in the Medicare system alone, $80 billion to the medical delivery system. We are an important purchaser, and we ought to demand that we get quality service for our constituents.

I hope you guys will just hammer the table today and make that known, because it will help.

Thank you.

Mr. **Konnyu**. Thank you.

Mr. **Weiss**. Pete, thank you. I know you have a busy day ahead of you. We appreciate your taking the time to appear before us.

We will ask our first panel of witnesses to join us now. Zettie Mae Hill, Jesse Green, and Judith Waxman, if you will take your places at the witness table.

I understand that you each have prepared statements, which will be entered into the record in their entirety, and you may then summarize your testimony, or provide whatever views you want to us within the time allocation that we have given to you.

Ms. Hill, if you would begin, I think that would be the best way to proceed.

First, let me express my appreciation to you on behalf of the entire subcommittee for taking the time and trouble to appear before us.

I would note also that we have been joined by our distinguished colleague from Ohio, Mr. Sawyer, at this point.

Ms. Hill.

STATEMENT OF ZETTIE MAE HILL, SOMERVILLE, TN

Ms. **Hill**. My name is Zettie Mae Hill from Somerville, TN.

I was a friend of Terry Takewell, and one afternoon, the 16th of September in 1986, there was a friend of mine come over, she got some mail. She got some of Terry's mail by mistake. She carried it over to the trailer, where Terry was, and she found him laying on the couch. He was real sick, and she came running over to my house, and said, "Ms. Hill, call an ambulance. Terry is dying." I said, "Oh, no." I called the ambulance.

When I did, I ran over to the trailer and I found Terry lying on the couch. He was very sick, and I picked up a piece of paper and fanned him trying to help him. He couldn't get his breath. He was moving around, trying every way he could to get his breath, and I tried to lay him back on the couch. He would grab his chest and holler. He couldn't; I had to raise him back up.

So the ambulance got there, and they got Terry and carried him to the clinic. Dr. John Bishop admitted him to the Methodist Hospital of Somerville. I returned home to turn my stove off; I left it on. I got in the car and picked up a neighbor of mine and said, "Come go with me over to see about Terry, and carry some of his belongings."

He went off in just his blue jeans. We went over there and when we did, he was outside under a tree by the pharmacy. We were going on down to the hospital, which wasn't but a block or two, and I heard a moaning over there and it was him trying to get our attention.

We turned around and got out, got Terry in the car and coming on home, we asked Terry what was he doing. I said, "Terry, what are you doing out here?" He said that they wouldn't keep him in the hospital. I said, "My lands."

We got him and carried him on home. We returned him back to the trailer on the couch, and I said to this neighbor, "I am going to run back over the house and call the hospital and see what was the trouble."

I called the clinic first and they were closed. Then I called over to the hospital and I said, "Is there anyone in the emergency room." I thought maybe someone was back there to put him in the hospital. They said, "No."

I said, "I want to know why you all didn't keep Terry Takewell. I believe he is dying." She said, "Because he didn't have any insurance and he owed the hospital a big bill."

So then we just put him in the trailer, and then we come back, sitting outside shelling peas, and a neighbor and myself watched over there. We could see him on the couch.

Along in the night, I guess it was about 7:30, late that afternoon, I ran over there and I called Terry, I said, "Terry."

Finally, he mumbled something and I thought he was in the bathroom. I said I won't go in. I said, "Terry, how are you doing?" He mumbled but I couldn't understand what he said, and I came back and I told Geraldine, a neighbor of mine, I said, "He might be in the bathroom. I won't go in on him."

So, I came back—I offered him supper, too. He couldn't eat. He said he was too sick, he couldn't eat. He said, "I believe I got pneumonia." So he couldn't take his insulin because he couldn't be eating. He was too sick to eat.

So, the next morning they come by to get him to go to work. I said, "My lands, he might have improved and maybe he wasn't as sick as I thought he was."

They honked the horn and I heard it. I was still in bed. So when I got up, I thought maybe Terry was able to go to work. The door was locked over there. But he didn't go to work. I found out when his friend come in that night, about 8, he came running over and said, "Ms. Hill, call the ambulance. Terry is dead."

I said, "Oh, no." I called the ambulance and I ran back over there and went in, and he was. He was laying with his hand on his chest, like this [indicating] kind of sideways, just like he was sleeping.

So, then I called the ambulance to come after him, and Dr. Matlock pronounced that he was dead and they carried him on. They ran an autopsy on him and they said that he died of a diabetic—that is just about all.

Well, I think it upset me real bad because I carried the boy to the hospital. They returned him home—he lived right by me. I brought the boy back home, and what upset me so bad, I thought if they had kept him over there, he would have looked a lot better if he had died in the hospital than it would have to send the boy home in the condition he was in.

He was death to me, and that is what he looked like. It upset me so bad. I said they could have kept him in the hospital and not sent him home to die. He didn't live but a few hours after they sent him home. He died sometime in the night.

Mr. WEISS. Thank you, Ms. Hill.

[The prepared statement of Ms. Hill follows:]

Testimony of Zettie Mae Hill

before the Human Resources and Intergovernmental Relations Subcommittee of the House Committee on Government Operations

Wednesday, July 22, 1987

My name is Zettie Mae Hill. I am a 62 year old widow and a retired textile worker. I live in Somerville in Fayette County, Tennessee. This is on the Mississippi state line about forty miles east of Memphis. The only hospital in the county is Methodist Hospital of Somerville. It used to be the county hospital until it was bought up a few years ago by Methodist Health & Hospital Systems, Inc. out of Memphis.

I first met Terry Takewell in April 1986 when I moved into the trailer park where he lived, right next door to my lot. He was about 21 years old. He made his living by working as a carpenter for a contractor, and he also made cabinets and did woodwork for people on the side. He was a nice boy, quiet, respectful and humble. He did not seem to have much family that he was close to, other than a grandfather in Texas. He lived in the trailer with two other young men and shared the rent.

Terry and I spoke to each other several times a week when we would run into each other. I learned that he was diabetic and had been since he was about nine years old. He was taking shots for his diabetes. He had been in Methodist Hospital before with his diabetes problem and he was worried about paying his bills because he could not get insurance.

At around 3:30 in the afternoon last September 16, a neighbor went to Terry's trailer to take him some mail that had come to her by mistake. All of a sudden she came running over to my place yelling, "Mrs. Hill, call an ambulance. Terry is dying." I called an ambulance and ran to Terry's trailer.

As soon as I saw Terry, I thought he was dying too. He was sitting on a couch kind of leaned over at an angle and just kind of panting. He looked real pale. He was wearing only pants and sweating very heavily. The couch was soaked. Terry was unable to lie down. I tried to lay him down and fan him, but he grabbed his chest and hollered. He couldn't stand to move, but he kept having to try to lean up to breathe. We asked him what was wrong but at first could not get an answer out of him. Finally we made out that he was saying that he was sick and that he needed help. He said he thought he had pneumonia.

The ambulance came and took him to a nearby doctor's office, because there was no doctor in the emergency room at the hospital at that time. I followed the ambulance to the doctor's office with Terry's clothing and other personal things. The doctor examined Terry on the ambulance stretcher for a few minutes, then sent him on to the hosptial in the ambulance. I later learned that the doctor had written out an order for him to be admitted to Methodist Hospital for his diabetes, to have certain tests done and to receive medicines and treatment right away.

When the ambulance left for the hospital, I remembered that I had left a pot on the stove back at home. I drove back home, turned off the stove, and picked up another neighbor before driving to Methodist Hospital of Somerville. We arrived at the hospital about 15 minutes after Terry left the doctor's office in the ambulance.

When we arrived at the hospital, we saw Terry under a tree beside the hospital parking lot. He was leaning forward with his head down and his eyes closed. He was shaking and breathing funny.

I stopped the car and my neighbor and I went over and asked Terry why he wasn't in the hospital. He said, "They put me out, Mrs. Hill. They wouldn't keep me." He said some man had come and got him out of the hospital bed. This man had taken Terry up under the arms and walked him out, barefoot and without a shirt, into the parking lot and left him there. I found out later that the man he was talking about was the acting administrator of the hospital.

I said to Terry, "You don't mean to tell me that, Terry." He said, "Yes, ma'am," that they had put him out because he didn't have any insurance or money.

My neighbor and I helped put him into my car, because he couldn't really walk. We took him back home and put him in his trailer on the same couch where the ambulance people had picked him up. He was still soaking with sweat and I brought over a fan from my trailer but Terry said he thought he had pneumonia and to leave the fan alone. He was hard to talk to because he could not get his words out plain. I offered him some food but he turned it down.

My neighbor and I were very upset because we still thought that Terry looked like he was dying. When I got back to my trailer I called the hospital and asked to speak to someone in the emergency room. But there was no one there and they hooked me up with a woman in the business office. I told her I thought that Terry was going to die and asked why did they not keep him. The woman told me that it was "because he doesn't have any insurance and he owes the hospital a big bill." I was nearly hysterical and said I could not believe what she was telling me. I asked why did they not at least send him to another hospital, and the woman said she didn't know.

I did later learn that the acting administrator of the hospital claimed to have offered to personally drive Terry up to the interstate exit, about 10 miles away, so Terry could try to hitch a ride over to Memphis to the Regional Medical Center.

My neighbor and I left Terry on the couch and sat outside shelling peas for about an hour where we could watch him. He still looked about the way he had, but we just kept telling ourselves that surely the hospital wouldn't have turned him out like that if he was as bad as he seemed.

After about an hour, Terry went into his bathroom. I tried hollering in to him to see if he was okay but could just hear him mumbling something back. My neighbor and I talked about it and decided that he was in the bathroom, that we didn't want to walk in on him, and that we ought to just leave him be. His roommate got home from work about 8:00 or so and so I went on back to my trailer and went to bed.

The next morning, I heard the fellows that Terry worked with come by and honk for him the way they usually did. I did not see him around all day but saw that the door to his trailer was closed, so I thought maybe somehow he had gotten well enough to go to work. He was so hardworking, I figured he might have gone if he had gotten at all better.

But that evening, September 17, when Terry's roommate got home, he came running over to my trailer yelling that Terry was dead. I went over and found him lying in his bed with one hand on his chest and the other on his head. An autopsy found that he had died of diabetes, which was what the doctor had ordered him to be admitted and treated for. He had died during the night, about 12 hours after the hospital administrator had left him in the parking lot.

I later testified as a witness before the Tennessee Board for *Licensing Health Care Facilities, when* it held a hearing about a complaint that had been filed against Methodist Hospital of Somerville over Terry Takewell's death. The Board is almost all hospital administrators, nursing home administrators and the like. They decided the hospital had not done anything wrong.

After Terry's death, I spoke with a member of JONAH, a community group in our part of the state. JONAH filed a complaint October 27, 1986 with the federal government about Methodist Hospital of Somerville turning Terry away. [A copy of the complaint is attached.] The complaint said that federal investigators could call me if they wanted to know more, but they never have.

Several phone calls were made to try to find out what happened to the complaint. Finally, six months after it was sent in, JONAH got back a letter [attached] saying the complaint had been received and would be investigated. It said, "please bear in mind that some investigations take considerable time."

The letter says the complaint has been sent to an office in Atlanta. JONAH has been told this office will just send the complaint to the same state board that already said Methodist Hospital of Somerville did nothing wrong in putting Terry out. And at that same meeting where I testified in April, the Board also refused to set guidelines needed so complaints like the one about Terry could be investigated when the Board was asked to do so by the federal government.

I have felt terrible about this thing ever since Terry died. My neighbor and I have talked over and over about why we did not try to take Terry to a hospital in Memphis or maybe the one in Bolivar. He looked to us like he was dying and the doctor ordered him put in the hospital. But yet we didn't do more than we did just because we figured surely Methodist Hospital must know what it is doing. We did not believe the hospital would just let a person die like that for lack of money.

JUST ORGANIZED NEIGHBORHOODS
AREA HEADQUARTERS

☒ Casey Building, Rm 217
416 E. Lafayette St.
Jackson, TN 38301
901-427-1630

☐ 18 S. Court St.
P.O. Box 495
Brownsville, TN 38012
901-772-5258

October 27, 1986

OIG Hotline
Office of Inspector General
Dept. of Health & Human Service
P. O. Box 17303
Baltimore, MD 21203-7303

Re: Medicare complaint

Ladies and Gentlemen:

I am writing in the name of JONAH, Inc., a community organization represented in five counties in West Tennessee, to report an apparent violation of Section 1867 of the Social Security Act, which was added by Section 9121 of the Congressional Omnibus Budget Reconciliation Act, enacted in April of this year. That new provision of the Medicare law became effective August 1, 1986 and applies to all hospitals which are Medicare providers. The new law requires any such hospital having an emergency department to provide an "appropiate medical screening examination" to anyone (whether or not a Medicare patient) who requests examination or treatment, to determine whether an emergency condition exists, and to provide such treatment as is needed to stabilize such patients.

The enclosed news clippings indicate that Methodist Hospital of Somerville, Tennessee, appears to have violated requirements of the new law in connection with the case of Terry Takewell, who died shortly after being denied treatment for financial reasons.

For further information, you may contact Ms. Zettie Mae Hill, Rt. 1 Box 11, Somerville, Tennessee 38068. Her phone number is (901)465-8574. She can confirm the circumstances as reported in the newspaper as well as adding further detail regarding the facts of the case.

I would appreciate being informed of any disposition of this complaint.

Sincerely yours,

Ernest Thomas
President, JONAH, Inc.

cc: Ms. Zettie Mae Hill

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration
OMB, OAS, DMOS, Corres. Br.

6325 Security Boulevard
Baltimore, MD 21207

APR 27 1987

MR. ERNEST THOMAS. PRES.
RM 217 CASBY BLDG.
416 E. LAFAYETTE ST.
JACKSON, TENN. 38301

Dear MR. THOMAS.

Re: Your Complaint to the Office of the Inspector General (OIG) Hot Line
(Case NO. 6-2980)

We referred your complaint to the Health Care Financing Administration, Atlanta Regional Office, Suite 701, 101 Marietta Tower, Atlanta, GA 30323.

This office will respond to you when the investigation is completed. Please bear in mind that some investigations take considerable time.

If you have any questions or additional information relating to your complaint, direct your letter to the above Regional Office.

Sincerely yours,

Marguerite Minus

Marguerite Minus
Chief
Correspondence Branch, DMOS

cc: HCFA Regional Office, Atlanta, GA
OIG

9-21-86

Dying indigent turned away from Somerville hospital

By Associated Press

SOMERVILLE, Tenn. — A dying man was turned away from Methodist Hospital last week because he owed the hospital money, a neighbor says.

Hospital officials denied that Terry Takewell, 31, was barred for treatment because of financial reasons, but they could not say why he was not admitted.

"I called the hospital and asked, 'Why didn't you keep Terry Takewell?'" said Zettie Mae Hill, a neighbor of Takewell at Middlebrook Trailer Park.

"The woman told me he had an unpaid doctor's bill and didn't have no insurance," she said. "But I said, 'He's dying. I believe death's on him now.' He just come on home and died."

Takewell, who had suffered from diabetes since childhood, came down with a cold about 10 days ago, said Bonnie McCoy, another neighbor.

McCoy said she took some mail to Takewell's trailer Tuesday afternoon.

"He couldn't breath. He couldn't hardly talk," she said. "All he could get out was 'Call an ambulance.'"

McCoy went to the home of Hill who called an ambulance then followed it to a clinic.

Dr. John Bishop, who examined Takewell, would not say what was wrong with the man, but he said he referred him to the hospital.

The ambulance took Takewell to the hospital and Hill went home to turn off her stove. When she returned to the hospital, she found Takewell on the side of the road.

"He said they asked him about money and he didn't have it," she said. "They asked him about insurance and he didn't have it."

She said she took Takewell home and called the hospital where a nurse told her he could not be admitted because of unpaid bills.

Hospital administrator Tim Staton referred inquiries to Methodist Hospital Systems of Memphis, which manages the Somerville hospital.

"Obviously, it's not our policy to turn away indigents," said Terry Lee of the hospital system's public relations office. "We're conducting our own internal investigation. We don't know what mitigating circumstances there were at the time."

Lee said Takewell had been treated at the hospital 12 times in the past several years, each time as an indigent.

He said the hospital's Somerville unit provides some $100,000 worth of indigent care each year.

Hill said she offered supper to Takewell on Tuesday night after he returned home, but he was too sick to eat.

The next morning, Takewell's employer came by to pick him up for work, but he was too ill.

Jackie [illegible], a friend, found him dead Wednesday night. The medical examiner's office said it would be two weeks before an autopsy report would be available.

"It just made me hurt so much, to see the way he was suffering there by the road," said Hill. "It was pitiful."

[illegible] 25, 1986 — THE TENNESSEAN ● 5-B

No probe planned in hospital's treatment refusal in death

SOMERVILLE, Tenn. (AP) — Fayette County authorities have no plans to look into the death of a 33-year-old man who was refused treatment at a hospital, County Executive David Smith said yesterday.

"As far as we're concerned, it's between the family and the hospital," Smith said. "We have no place to conduct an investigation. We don't have any venue that I know of."

Terry Takewell died last week, less than 24 hours after being turned away from Methodist Hospital of Somerville.

A neighbor, who called an ambulance to take Takewell to the hospital, said he told her that he was refused treatment because he had no money.

Zettie Mae Hill said a hospital employee told her the same thing when she called the hospital to ask about Takewell.

But Terry Lee, a spokesman for Methodist Hospital Systems of Memphis, which owns the Somerville hospital, said Takewell was not in a "life-threatening condition" when he was examined at the hospital on Sept. 16.

Lee said Takewell was referred to the hospital by Dr. John Bishop. He said that the acting hospital administrator, Tim Staton, checked with Bishop to verify the need for admission because Takewell had been an uncooperative patient in the past.

He said Takewell, a diabetic, left the hospital without a doctor's dismissal order in July.

Lee said that Staton asked Takewell to sign standard hospital consent forms last week, but the patient refused.

"Had his condition been assessed as a life-threatening emergency, by either Dr. Bishop or the medical personnel at Methodist Hospital of Somerville, he would have been admitted," Lee said.

Takewell left the hospital and was found waiting along the road by Hill who took him home. Takewell, who had been suffering from a bad cold, was found dead the following day. The cause of his death has not yet been determined, the county medical examiner said.

Lee said he could not explain why Takewell thought he was being refused admission for financial reasons.

Construction of the Somerville hospital was financed by Fayette County's Health and Education Facilities Board, which issued bonds for the project, the county executive said.

But about 15 months ago, the 50-bed hospital was sold to Methodist Hospital Systems which had been managing it for the county.

"The county no longer has any financial interest in the hospital," Smith said.

Although the county no longer owns the hospital, Smith said Methodist Hospital Systems is under contract to provide medical care to the county's indigent patients.

"We appropriate $170,000 a year to pay for the treatment, and that money is used up every year," he said. "I feel certain that they do spend the money because we have a good number of low-income people in Fayette County."

Smith said there is no authority for the county to begin an inquiry.

"It is a tragedy, of course." ■

Nashville Banner

FTERNOON, MAY 1, 1987. □ Nashville, Tennessee □ Vol. 113, No. 211 □ 52 pages □ 6 sections □ First edition □ TODAY'S NEWS TODAY

Death case vote backs hospital

By Rex Graham
Banner Medical Writer

In a split decision, the state board that regulates hospitals said Methodist Hospital of Somerville did nothing "detrimental" to an indigent patient who died several hours after an administrator escorted him out the door.

Terry Takewell, a 21-year-old diabetic, was ordered by a staff doctor to be admitted on Sept. 14, 1986. The hospital said it refused to admit the man and perform the laboratory tests the doctor had ordered.

A death certificate said Takewell died the next day of the same complications evident when ambulance paramedics laid him on a Methodist Hospital bed.

The 13-member board voted 8-4 along "philosophical" lines that the hospital was within its rights by refusing to treat the man. The board agreed that the doctor told an administrator that the man "would probably be all right."

Furthermore, the board said Methodist acted properly because the man refused to fill out forms that would have qualified him for free hospital care.

Takewell's outstanding bill at Methodist was $9,424.71. The hospital had turned over his account to a collection agency, and Methodist's chief administrator posted a memo in the emergency room that Takewell not be admitted again without contacting him or the director of nursing.

The case was brought by the state Department of Health and Environment. Leslie A. Brown, an executive director in the department who attended the trial, refused to comment after the decision.

The board, which never in its history has revoked or suspended

Please see PATIENT, page A-10

. . . Patient

the license of a hospital, voted 7-4 that Methodist did fail to notify the Tennessee Board for Licensing Health Care Facilities within 10 days of the incident, as required by law.

But several board members argued that "incident" was too strong a word to use in the charges that were filed against the hospital.

"When you make the newspapers it is an 'incident,' " argued board member Carney W. Wright. But Thelma M. Dickerson said the affair should be referred to as "an occurrence." The board finally settled on "events which occurred."

The board agreed the Somerville hospital should "develop policies and procedures for the assessment of all patients" who come to the 50-bed facility.

And it agreed the hospital also must "develop criteria for determining the severity of illness of patients at the hospital" and other guidelines.

But Edward A. Purdue pointed out the hospital was supposed to be doing these things.

Nevertheless, the board voted unanimously to require Methodist to follow the recommendations and file a report in six months stating how they are complying.

Takewell, who had suffered from diabetes since age 10, was hospitalized at Methodist seven other times. Officials said he was uncooperative about filling out forms that could have qualified him for free hospital care.

But a psychologist who testified on behalf of the hospital said Takewell suffered from a reading disability and had a reading comprehension level at the fo grade level or below.

"Terry needed special teaching approaches, attention and materials to move forward academically in light of his disability," said Dr. David Holt.

The day before he died, hospital officials said Takewell again refused to give them information about his income.

A patient who briefly shared room 123 with Takewell testified at the three-day trial that assistant administrator Tim Staton told the diabetic he wasn't sick enough to be admitted, despite Dr. Tom Bishop's admitting order.

"Mr. Staton picked him up under the arms and escorted him down the hall," said former Methodist patient John T. Murphy.

Takewell's neighbor at a Somerville trailer court called the ambulance that took him to the hospital. She testified that, when she drove to the hospital to check on the man, she found him sitting under a tree along the hospital driveway. He was rocking back and forth. Takewell was wearing blue jeans and no shirt or shoes, the neighbor said.

Neighbors, paramedics and other witnesses testified Takewell was hyperventilating when he was removed the hospital. A doctor testified that symptom was consistent with "terminal ketoacidosis," a serious complication of advanced diabetes.

But several board members said they should pay attention to the law and not their sympathies.

Mr. **Weiss**. Mr. Green.

STATEMENT OF JESSE GREEN, BROOKLYN, NY

Mr. **Green**. My name is Jesse Green. I am from Brooklyn, NY. On April 13, 1987, I took my roommate, Iva Boyce, to NYU Medical Center. He was very sick.

Iva had worked for TWA for 11 years. He had insurance and a good job but, the year before, they went out on strike and he was left without any insurance or money. His funds ran out.

We started to notice in January that he had started to lose weight; he was severely depressed. Most of the time I thought it was simply because he wasn't strong. He started to lose weight and he started to look really sick. Early in April, he started to stay in his room and he complained about being in pain. He couldn't go see a doctor because he didn't have any money to pay a doctor. He didn't feel he was sick enough to go to the hospital, even though he really looked bad.

On April 12, I bought a thermometer and made him take his temperature and I noticed it was really high. It was 104.

I told him that he should go to a hospital or doctor right away, but he again complained about not having any money and they wouldn't let him in. He took lots of Tylenol and cold rubdowns and everything, and his temperature came down, but I told him, the next day no matter what, if it was up, we would go to a hospital first thing.

On Monday morning, I got up and I called a few friends of mine and also Brooklyn Legal Services to ask what our rights were if we went to a hospital, for not being turned away. He had no insurance or Medicaid. And I knew that a lot of hospitals in New York will not see you; they will turn you away.

I was told by Betsy Imholz about the Hill-Burton Act, which allowed certain hospitals to see patients who didn't have any insurance or money. So we decided to go to NYU Medical Center, which is in Manhattan.

When we arrived there, someone came right out, they took him in and saw him right away. One of the reasons why we decided to go to NYU in the first place was, the year before, a friend of mine was very sick. He had many of the same symptoms that Iva had. He was really sick.

I took him to Bellevue because he wanted to go there. We waited in the emergency room more than 8 hours before anyone would even see him. There were lines. If you go there right now, you will see a room full of people and many of them are very, very sick people. They have to wait.

My friend did not even see a doctor for more than 8 hours. It was about 48 hours before they gave him a bed.

Bellevue is just one hospital. There are other hospitals nearer to Brooklyn, but that is also a problem when you are very sick.

Another friend of ours had gone to NYU and he told us how good it was and how someone saw him right away. He couldn't believe the treatment that our other friend had. He said if I was sick, it was worth the trip to NYU. It was a good hospital.

I called Brooklyn Legal Services and they explained to me about the Hill-Burton Act. They told me that more than likely what they were going to try to do, since I didn't have any insurance or Medicaid—or Iva didn't—that they would probably try to find some excuse to transfer him.

But she said, you have a right; stand your ground. Ask for somebody, an administrator, if they try to turn you away. But when we did get there, like I said, someone came and saw Iva right away. I was really impressed.

We only waited 5 minutes, and they started taking his temperature and when the woman was doing in-take, she asked him did he have any insurance, he told her no. No Medicaid? He told her no. He also went through the same story explaining why, that he was unemployed and didn't have any insurance.

He was quite proud. He never tried to apply for any benefits. He was always hoping he could get his job back and his benefits back.

The doctor convinced us right away, he said, "This man is very sick. It is a good thing you got here. His temperature is about 105."

Recently, I had heard stories about people going to the hospital and going into shock when they had high temperatures and dying. I was really afraid that he was that sick and he was dying when I took him there. So we instantly felt relieved that they seemed to be doing everything.

In the meantime, the doctor started asking lots of questions about his health and took his temperature and explained that he would need x rays and just a whole lot of questions about the history of his illness.

He took us into an examination room, which was right next to the in-take desk. He stepped out, spoke to a lady and he came back. He explained to us how sick Iva was and that he needed to be hospitalized and that he was to make arrangements to transfer him.

I said, "Wait a minute." It really dawned on me how sick this guy was. It was obvious. I asked him, "Why transfer him if he is sick?" He told me that they didn't have any beds and he explained that he didn't have a regular doctor. He just came up with all these excuses.

I told him if it was because Iva didn't have any insurance or Medicaid, that this was a Hill-Burton facility and his bills would be taken care of. He said that insurance was not the excuse. He tried to convinced me and I said, look—I asked to speak to an administrator.

It was obvious to me that the reason why they wanted to transfer him wasn't because they didn't have beds. Iva had many symptoms. He said over and over again how he should be hospitalized.

I told him that we wanted to stay here. He said, "You might have to wait 48 hours for a bed, and the law wouldn't allow you to wait more than 48 hours," or something to that effect. He stepped outside and talked to someone and came back in and again told me that Iva should be transferred; that he was very sick. He told me that if anything happened to him it was not going to be his responsibility.

I told him that we would prefer to stay here. I again asked to speak to someone. A woman came down. I called patient services, I believe, and a woman came down named Pat Granderson.

I explained the whole problem to her and I told her what I knew about Hill-Burton and what it meant.

She told me that it did not mean that they had to treat everyone. She was really kind of short with me, like—it doesn't mean that we have to treat everyone who comes in. She said that she would look into it and she would get back to me.

I was worried about this. It was late in the evening. I was thinking that we would be around here all night before something would happen.

Finally, I went back to the telephone and I called Brooklyn Legal Services and I spoke to a lawyer named Jane Stevens. I explained the situation and she agreed with me that she felt this was a delaying tactic, and that she was going to call everyone she knew who could do something before everyone left to go home at 4 or 5.

I gave her the names of all the people I had talked to, besides the woman from patient services. Someone came down from the nursing department and said, "Mr. Green, the reason has nothing to do with insurance. We just don't have any beds available."

Again, when I spoke to the doctor, he looked me in the eye and told me that this was my responsibility; that if I didn't transfer him, this was totally up to me.

I looked at Iva, at the care that he was getting in this emergency room. You know, he had got a lot of attention. He was in a little room. They seemed to be monitoring him. It dawned on me that if we went anywhere else, he wouldn't be getting that much care.

I asked the doctor what type of treatment would he get in an emergency room—what are you worried about? He said things like special tests. I asked what kind of special tests, and he said, I don't know but there are special tests that we can't do here. OK?

I knew then that it was a matter of them trying to ship him away, so I made the decision to wait until a room became available.

After talking to Jane—I called Jane back, and Pat Granderson came down and spoke to Iva, and spoke to me. It was a little more than hour, but during this time—even though it was a short amount of time, it seemed like a real long time because we weren't sure what was going to happen to us.

In the meantime, Iva was starting to look delirious and he looked sick. Now this time she came down and the attitude was different. "Oh, Mr. Green. It looks like a bed might be available, and I explained to Mr. Boyce a bed might be free. You might have to wait, but something is going to come up."

I later learned that, after I called Jane Stevens, she called Judy Wexler at the Community Action for Legal Services, and then she called the director of the hospital division of the office of health service management in New York State. A lot went on behind the scenes; they called a lot of people and eventually they got in touch with Carlos Perez who called NYU Medical Center and let them know that he was worried about this particular case.

I believe it took all this high-level intervention to make them decide to help Iva.

During the time that we stayed there, Iva's temperature went up to 105.8. He was a little delirious and I made it clear what was going on. If he did want to transfer, I would have transferred him. But he also was aware—you know, it is not just Bellevue, the public hospitals, Brooklyn hospitals and other hospitals, they treat you a certain way if you come in and you can't pay for it.

Even in that hospital, we heard the woman who did in-take explain to a Latino man, she didn't care what he did if he didn't come back here with $105, he was not seeing anyone.

Now she was able to say that to him and get away with it, but it was a difference the way they treated me and Iva when we were there.

Iva was later diagnosed as having advanced tuberculosis and at the time they thought he had pneumonia and we weren't quite sure what it was. But one thing, over and over again, people have emphasized how lucky we were that we did get to this hospital, that we were seen and treated and taken care of.

I live in Brooklyn where there are lots of poor and minority people. I see around me, and often I hear stories about people getting sick. These are horror stories that you are not going to hear about.

When people go to a hospital and they are turned away, they go home. Often they might give you some medicine and you go home. People are not aware of their rights. When I looked in the emergency room in that hospital, I looked everywhere for any information about the Hill-Burton law or act on the walls. I looked everywhere because I thought it would help me as I was explaining to them why they should not reject Iva.

There was no information on any of the walls. I think that that is a problem. I think they have to make information available to people so they will know about it.

There are laws that already exist; they just have to be reinforced. Again, how to go about doing it—people don't just really know. When you are really sick, the last thing you want to do is explain why they should keep you when you don't have insurance.

In this case, I think Iva was lucky that I was around and we had other people who could explain these things to me. I was also not ready to give in. It made me nervous to think that my friend could die because of my decision not to transfer him to another hospital. I was worried about going to Bellevue, to be perfectly honest with you, which shares the same grounds with NYU.

The difference is seeing a doctor in 5 minutes, and seeing a doctor in maybe 8 hours.

Anyway, that is pretty much what I would like to say.

[The prepared statement of Mr. Green follows:]

TESTIMONY OF MR. JESSE GREEN

JULY 22nd, 1987

OVERSIGHT HEARING OF THE HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE OF THE COMMITTEE ON GOVERNMENT RELATIONS

IVA BOYCE, 36 years old, and I, Jesse Green, have shared an apartment in Brooklyn, New York since June of 1981.

Iva worked for T.W.A. for 11 years as a flight attendant until March of 1986 when he went on strike and was shut-out along with 4,000 other employees. Since that time he has been unemployed (his unemployment ran out). His union is still in court trying to get his job back. During the year that he has been unemployed he used up any funds that he had for food and for rent and he no longer had health benefits. Iva never applied for welfare or Medicaid because he believed he would soon go back to work. But that did not happen, and he became very depressed, which may have led to him getting sick.

As early as January of this year, we noticed that he was starting to lose weight. And by March he looked bad, and felt sick. He felt however that he could not go to a hospital because he had no way to pay the bills. In early April he stayed in his room and he was in pain, he was getting night sweats and fevers and lost more weight and on April 12th, I took his temperature and it was very high.

I told him that he should go to a doctor. But we didn't have money. Most doctors charge more than a hundred dollars on the first visit. The hospitals would not even see you if you didn't have $100 or insurance. With cold rub downs and lots of Tylenol, his fever came down. But by Monday, April 13th, in the morning it was up again and rising.

I knew that I had to get him to a hospital, as it was very obvious that Iva was real sick. I was afraid that he would die.

Last year we had a friend who had many of the same symptoms and he went to Bellevue, a public hospital in Manhattan, that shares the same grounds and many of the doctors at N.Y.U. Medical Center. He waited in the Emergency Room for almost 48 hours before he got a room, and it was more than 8 hours before he even talked to a doctor; (this was because the emergency room at that hospital was so crowded). We did not want this to happen, and we knew that certain hospitals were better than others. Another friend told us about N.Y.U. Medical Center, also in Manhattan, and how he was able to be seen right away by a doctor. He did not have to wait there for hours to see a doctor. He had first rate treatment at N.Y.U. We also were worried about being turned away because of a lack of funds or insurance.

Early on Monday, April 13th, I called Brooklyn Legal Services, to ask about our rights to hospital care. I wanted to know if there was a way to not be turned away from N.Y.U. because we did not have money or medical insurance to pay for the emergency room visit. I was told about the Hill-Burton law, and that N.Y.U. was a Hill-Burton hospital by Betsy Imholz, an attorney at South Brooklyn Legal Services. She told me that they may try to turn us away, but if they did I should ask for treatment under the Hill-Burton law. She informed me that if they did not know about it, to ask to speak to someone in charge or an administrator. She also told me that they may try many tricks in order not to treat Iva at N.Y.U., but that I should stand my ground and to call back if I had any problems.

We arrived at N.Y.U. emergency room around 3 p.m. in the afternoon. Right away we were told by the doctor that Iva had 105 degrees temperature, he confirmed the high temperature. They started the hospital intake process at the same time. The doctor said to me that this is a very sick man. The woman who was doing the intake asked if he had any insurance, and he explained that he did not. She asked if we had any money to pay for the ER fee. We told her that we did not. Iva explained why he was unemployed and did not have insurance or money or Medicaid. We overheard the same woman explain to a Hispanic man that if he did not return with $105 he could not see anyone.

The doctor started asking lots of questions about his health, the history of his sickness, and seemed very concerned about his condition. He told us that we were wise to get here, that Iva was a very sick man.

When we arrived at the N.Y.U. ER, the doctor, Dr. Schwartz, took blood and tapped Iva on the chest. He said that he had to get X-rays and asked lots of questions. He stepped out and was talking to the woman who did the intake and after a while he came back and said that Iva was a very sick and would have to be hospitalized, and he was going to make arrangements to transfer him. Right away I asked if he was so sick why transfer him. I told him that even though we did not have money or insurance, that we wanted Hill-Burton services, just as I had been told to do by Betsy Imholz at Brooklyn Legal Services. As best that I could, I explained what I know about the Hill-Burton law and that N.Y.U. was such a facility, and that Iva could not be turned away because he did not have a way to pay for services. I also said that if he was not eligible for Hill-Burton, that there was always Medicaid, and that N.Y.U. would be covered for Iva's treatment.

I told him that I expected N.Y.U. to turn us away because of lack of insurance, and I asked him to check the HIll-Burton law or to let me talk to an administrator or someone who knew about the law. He stepped outside and talked to someone on the phone and to the woman who did intake, but I did not hear what they talked about. When he came back into the room, he again said that Iva was very sick, and if we did not agree to a transfer it would be my responsibility if anything happened to him. I asked him why we could not wait until a bed was free. He said that it could take more than 48 hours and that it was against the law to spend more than 48 hours in the Emergency Room. Besides he said that Iva could not get the proper care in the Emergency room.

I asked what care was he worried about Iva not being able to get. He said "some important special tests" that they could not given in the emergency Room, but would not tell me what test. He also said that another problem was that Iva did not have an admitting doctor.

The doctor gave me the name of a person to talk to and a short while later a woman, Ms. Arsene, a head nurse supervisor, came down and took me into a little room and explained that there were no beds, and that he had no admitting doctor. She said that they were not trying to transfer Mr. Boyce for a lack of funds. She said that we were free to wait, but that there may not be a bed free and Mr. Boyce need treatment right away, and that they could not be responsible for his care if we did not agree to a transfer. I was at this point very worried, because they made me feel if something happened to Iva that it was my fault because I had the chance to have him transferred and did not agree to this.

I called Patient Services at the hospital and talked to a Pat Granderson. I explained the problem and I asked her about Hill-Burton and what I thought it meant. She told me that it did not mean that they had to take and treat everyone. I felt that she was a bit short with me. She told me that she would look into it and get back to me. This was after 4:30 in the afternoon, and I was beginning to get worried that this was a delaying tactic. Right away I called Brooklyn Legal Services again, and spoke to Jane Stevens, another attorney there. I told her that no one seemed to know about the Hill-Burton law and how Iva seemed to be getting worse and I did not think that it was a good idea to have him transferred in that condition.

Jane Stevens said that she would call everyone who she felt could help and that he had to work fast before people went home at 5 p.m. I gave her the names of the people that I had talked to. She said that she would try her best and that I should call back. An hour or so later, Pat Granderson came down and talked to Iva, and she also talked to me. She seemed very different now. She was not short with me as she had been before, and now this time we were free to wait in the Emergency Room, and she said that it looked like there was a good chance that a bed would be freed up. It was also no longer a problem that Iva did not have an admitting doctor. There seemed to be new doctors on the case. Iva was put on a Hyperthermia machine at 8 p.m. when his temperature went up to 105.8. By the next morning Iva had a room. The admitting diagnosis was an unspecific type of pneumonia. Later an advanced tuberculosis was diagnosed.

I later learned that this had all happened, and the tone of the hospital had changed because of several phone calls that had been made. Jane Stevens had contacted Judy Wessler at Community Action for Legal Services. Ms. Wessler had then contacted the director of the Hospital Division of the Office of Health Systems Management in the New York State Department of Health to intervene at N.Y.U. Hospital. It appeared that there had been several other complaints against this hospital filed with the State Department of Health, because of their unwillingness to serve poor and minority people. The director of the Hospital Division then called the deputy director of the New York City regional office of the State Health Department to intervene at the hospital. Mr. Carlos Perez called N.Y.U. Medical Center and said that the state was concerned about this case. This is obviously why the hospital changed their position on giving Iva a bed. But it took this high level intervention to make the hospital decide that they could make a bed available.

During his stay, Iva was treated wonderfully by the nursing staff, but his doctors often complained about his lack of insurance. One doctor complained and raised questions about why a man his age was unemployed for a year with no health insurance. This doctor also warned that N.Y.U. could not absorb Iva's medical costs.

On May 6th, I filed a complaint with the New York State Department of Health because the hospital was trying to release Iva before he was well or had a way to take care of himself. The hospital actually kept Iva a week longer after they had a visit from the Health Department because of the complaint that I filed.

When Iva was discharged, he was referred for follow-up care to a public hospital in Brooklyn. One of the first things when he arrived was a nurse asking how he had been a patient at N.Y.U. when he had no insurance or Medicaid. She was amazed that he had been a patient at N.Y.U.

RECOMMENDATIONS

There must be an enforcement of all the laws and an effort to inform people of their rights. I walked in the Emergency Room and looked everywhere for information on the Hill-Burton law, but there was no printed information about Hill-Burton or any other program that would help.

The laws must be enforced by getting information out to people, making it available and explaining this information in a way that people can understand it.

Mr. **Weiss**. Thank you, very much, Mr. Green.
Ms. Waxman.

STATEMENT OF JUDITH WAXMAN, MANAGING ATTORNEY, NATIONAL HEALTH LAW PROGRAM

Ms. **Waxman**. Thank you, very much, Mr. Chairman, and members of the subcommittee for inviting me to testify today. I represent the National Health Law Program, a program which is funded by the Legal Services Corp. to provide professional advice and assistance to legal service lawyers and clients such as those that you see here today, on issues that involve access to health care.

We have extensive and ongoing contact with poor people and their representatives throughout the country. Our testimony today is based on our experience with those lawyers and those clients.

I have included in my testimony some more examples of incidents, such as the ones you have heard about this morning, and I assume they will be part of the record.

Mr. **Weiss**. Your entire statement will be entered in the record.

Ms. **Waxman**. Thank you. Unfortunately, the examples I cite, which have all happened since the enactment and effective date of the COBRA statute, and the ones you hear about today are not uncommon. One of the basic problems that is evidenced by the testimony so far is that the statute requires hospitals to stabilize patients. It is often very difficult to create a legal definition of a medical condition.

What results is that physicians will say an individual is stabilized, even though he or she may in fact still be very ill and the person is transferred for economic reasons. Therefore, although the physician may meet the strict criteria of the law, many poor people are being shuttled around the country, literally going from facility to facility because of economic reasons.

That is the crux of the problem that we must address today.

When we hear of dumping problems, we advise lawyers to send complaints to HHS, citing the COBRA statute and the other statutes that have been mentioned today that are within the agency's jurisdiction. Frankly, lawyers are hesitant to use this process because they have one of two experiences; either they never hear a response at all from the agency, or the response is so delayed that their clients are totally discouraged by the wait and the meagerness of the ultimate results.

We also advise attorneys to look at their State statutes. You may know, a number of States are starting to pass their own statutes that are actually more stringent than the Federal law. In fact, Tennessee, and we do have representatives from Tennessee here today, has included in its statute a provision forbidding economic transfers for in-patients. Hopefully they will be getting at the real core of the problem there.

Texas, also, has an excellent provision which requires that all hospitals send a memo of transfer with every single patient that is transferred. The memo must be signed on both ends of the transfer by the physician that is in the transferring hospital, and the one that receives the patient.

This written record puts every hospital and physician on notice as to what the requirements of the law are and it strengthens the accountability of those physicians since they have to sign their name. It also creates a permanent, written record of every single transfer and allows the State to have much better enforcement capabilities.

This provision can either be added into the Federal statute, or added into the Federal regulations, to help enforce the COBRA law.

California has a bill—it's not law yet—which requires posted notice and written and oral communications about the requirements of the law and would get at some of the problems Mr. Green has mentioned. Again, the Federal law, the COBRA statute, requires no such notice.

This provision is a tremendous improvement over the Federal law in that it allows individuals to participate in the enforcement of the statute. It gives individuals the knowledge to demand the appropriate compliance.

These examples and others illustrate that the Federal law is a great first step to solving this problem, but in fact it is just a first step.

Unfortunately, more stringent provisions are needed because a number of hospitals do attempt to circumvent the law. They will find new loopholes in the strict letter of the law.

A prime example, which you may have heard about, is the one in McAllen, TX, where the regional medical center refused to take any transferees who were uninsured or Medicaid eligible. They actually made this blanket announcement to this effect.

Under the Federal law, no physician could actually force the facility to agree to take any transferees. What finally happened and brought the situation to a climax was the following incident. The physicians in a small, ill-equipped hospital were faced with the prospect of having a boy in their possession who had a bullet in his brain and they just did not have the capabilities to take care of him.

The physicians decided that they should just release the boy and tell the parents to take him right to the McAllen regional facility. That way, if the boy showed up at the door, the Federal law would require McAllen to take him in, which they did. McAllen staff did then treat him, but the treatment was so delayed, he died a few days later.

It seems to me that McAllen felt that they did not violate the letter of the law, although they certainly violated the spirit of the law. Here is an example of where one provision should be added to prevent facilities from getting around the law in that way.

[See appendix for detailed explanation, pp. 461–463.]

Ms. WAXMAN. Another example of the inadequacy of the current law is evidenced by a rural facility in Idaho, where a family took their daughter who had severe stomach pains and a high fever, to the emergency room. They arrived at a time when there was just on-call physicians. The facility did not have a person in the emergency room at all times. Actually, they had a nurse; they did not have a physician in the emergency room at all times.

The nurse made no initial assessment of the severity of the child's problem, and when she learned the family didn't have any insurance, she simply told them that the doctor would not be able to come for quite a few hours. They were left sitting and waiting, untreated and distraught, for a very long time. In fact, this child ultimately was adequately treated, but there could have been disastrous results.

Again, the Federal statute really needs a change to require physicians that are on call not to refuse to come into the facility simply because the patient doesn't have any insurance.

One other inadequacy of the Federal law has been brought to our attention by hospitals that are dumped on. Many hospitals of last resort, some of which Representative Stark referred to this morning, are the facilities that receive the inappropriate transfers regularly. While the Federal law allows them to bring a private right of action against the hospitals that dumped on them, they are very hesitant to do that. They are often in the same hospital association with the other hospitals in their area, and political pressures prevent them from suing their associates.

If the Federal law had a requirement that all hospitals and physicians were required to report such violations, then hospitals would be able to get around those political pressures and in fact enforce the Federal law in a much stronger way than it is now being enforced.

My list of changes is certainly not exclusive, and I know other people this morning will mention some other changes that we certainly would agree are important, but I didn't want to finish this list without talking about the administration's enforcement.

Obviously, no matter how strong the Federal law is, it is virtually useless without administrative enforcement. As far as we have seen, the HHS enforcement of the COBRA statute is extremely negligent. There are three various branches of the agency which will send representatives here to talk to you today, that need to coordinate their activities to enforce this law. From the complainant's perspective, there appears to be no coordination whatsoever.

HCFA, in fact, has delegated much of its responsibilities to the States, and yet given the States very little guidance on how they should investigate the complaint. Additionally, as I am sure you know, the law as enacted in April 1986, went into effect almost a year ago and still we have not seen any proposed or final regulations.

We really appreciate your interest in this problem and your desire to question the administration on this.

If the statute is strengthened and enforced properly, it certainly can go a long way to solve the serious problems of people who are being denied emergency care because of lack of ability to pay.

The suggestions I made for improvement will reinforce the individual's ability to receive, and HHS' ability to assure access to care.

I do have to say one other thing, however. I feel I would be derelict in my responsibility to my clients if I ended just there, and just talked about this statute. I think, that as evidenced here, many hospitals will go to great lengths to get out of serving people that are uninsured. The real problem is the fact that people in this country are uninsured.

For better or worse, our health care system is based on a payment system of providers primarily through private insurance and government funded insurance, and most people in this country do have that kind of coverage.

But according to the Census Bureau, 37 million Americans, men, women, and children, fall through the cracks because they have no coverage. Unfortunately for a variety of reasons, that number is growing dramatically, at the rate of about 1 million people a year.

There are also about 50 million people who have inadequate insurance. The uninsured are people who are primarily workers and their families, who have no insurance through their place of employment and have too much income to qualify for Federal programs. One-third are children and almost three-quarters are members of families where there is at least one person who works full time.

It is these people who are at the highest risk of being dumped. As already mentioned this morning, the Robert Wood Johnson Foundation did a study that showed 1 million people last year were actually denied care because they could not afford it, and another 14 million never even sought care because they knew they couldn't afford it. The only way to ultimately solve the dumping problem is to get some kind of coverage for each person so that hospitals will know that everybody who comes to their door has some kind of coverage, and they will be reimbursed.

If we don't have that kind of system, then the hospitals will, unfortunately—not all, of course, but some will—find loopholes and ways to dump or otherwise get rid of patients who are going to cost them money.

I want to really end on that note. Unfortunately, stories such as the ones we have heard will continue to occur until there is some kind of universal coverage attached to the individuals.

A universal coverage would ensure that every person gets crucial health care and hopefully patient dumping can then become a practice of the past.

[The prepared statement of Ms. Waxman follows:]

Testimony of

Judith G. Waxman
National Health Law Program

before the

Subcommittee on Human Resources and
Intergovernmental Relations
Government Operations Committee

Hearing on Patient Dumping

National Health Law Program
2025 M Street, N.W.
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Washington, D.C. 20036

July 22, 1987

Mr. Chairman and members of the Committee

We appreciate your invitation to testify today on a matter of great importance to our clients.

The National Health Law Program is a health law support center funded by the Legal Services Corporation to provide professional advice and assistance to legal services advocates and their clients. We have extensive and ongoing contact with poor people and their representatives throughout the country regarding a variety of health subjects.

Our testimony is based on our experience in providing professional assistance to clients and our extensive knowledge of the problems of access to health care and in particular the concerns our clients have raised with us about the subject of today's hearing, access to emergency room care.

You have heard this morning about two examples of the difficulty poor people have in obtaining emergency care. Unfortunately these are not isolated incidents. We hear of cases all the time where people are turned away at the emergency room door.

In Florida, for example, an indigent woman who suffered from severe interruption of blood supply to her right arm sought emergency treatment at a hospital emergency room. She suffered from loss of use in her arm, extreme pain, lack of pulse and coldness to the touch. She was in danger of severe tissue damage, possible gangrene and eventual loss of her arm or death.

The facility at which she sought care told her not to return to the emergency room until she had the fees to pay for treatment or "until her arm and hand turned black."

Another example comes from Fredricksburg, Virginia where a woman who was six and a half months pregnant went to the local hospital when she began having labor pains and passing blood clots. Once at the hospital, the woman was told by a nurse that because she did not have a private doctor, nothing could be done for her. After a few hours she was told to go on her own to the University hospital which was a two hour drive away. The doctor on duty at the University hospital said that had a doctor treated her earlier, he could have arrested the premature delivery. However, because so much time elapsed a premature baby was born that afternoon and died a few minutes after birth.

When we get calls about such incidents, we advise people to complain to HHS, asking for enforcement of the COBRA provision, the subject of this morning's hearing, and the Hill-Burton obligation, if appropriate, which requires certain facilities to treat emergency patients regardless of their ability to pay. We also advise them to consider citing, if appropriate, violations of Title VI of the Civil Rights Act, which prohibits racial discrimination and Section 504 of the Rehabilitation Act, which prohibits discrimination on the basis of handicaps.

We also advise attorneys to rely on their state statutes. A number of states have "emergency room" statutes that go beyond the requirements of the federal law. Texas, for example, includes an excellent provision which requires that all hospitals send a memo of transfer with each patient when he or she is transferred. This memo which must be signed by physicians on each end of the transfer creates a written record of every transfer. The written record puts every hospital and physician on notice about the requirements of the law and aids the state in assuring compliance.

California is considering a bill which requires posted notice, and written and oral communication advising patients of their right to emergency care, treatment and appropriate transfer procedures. No such federal requirement exists at this time. This provision is a tremendous improvement over the federal law in that it allows individuals to participate in the enforcement of the statute by giving them the knowledge to demand appropriate compliance.

These examples and others I will discuss illustrate that the federal law is a great "first step" in solving the patient dumping problem, but it does not go far enough. Unfortunately, more stringent provisions in the law are necessary because experience has shown us that hospitals will attempt to find loopholes through which they can circumvent this law.

A prime example is the case in McAllen, Texas where the Regional Medical Center refused to take any transferees who were uninsured or Medicaid eligible from the small lesser equipped hospitals. Under the federal law, no physician could force McAllen to agree to take transferees. The physicians, from a small rural facility, were unsure how to react when McAllen refused to take an uninsured teenager who had a bullet in his brain. Finally, they released the boy and told his parents to take him directly to McAllen even though they lacked appropriate permission. Because the boy simply showed up at McAllen's emergency room, the hospital had no choice under the law but to provide him emergency treatment. The boy was operated on shortly after he arrived at McAllen but died a few days later. Certainly McAllen violated the spirit of the anti-dumping law, yet they feel justified because they were not violating the letter of the law. The federal law should be strengthened to close this loophole.

Another example of the inadequacy of the current law is illustrated by the family in rural Idaho that went to an emergency room with their daughter who had severe stomach pains and a high fever. This incident occurred during the part of the day when the emergency room has no regular attending physician, but uses an on-call system. The nurse made no initial assessment of the severity of the child's condition. Instead, after ascertaining that the family had no insurance, told them that the doctor said he would be unable to come to the emergency room for several hours. They waited unexamined and untreated and emotionally distraught for a very long time. Although the child was ultimately adequately treated, the results could have been disastrous. Again, the federal statute is insufficient because it does not specifically address the problem of the emergency room whose physicians are "on call" and refuse to respond on the basis of the patient's ability to pay.

Another inadequacy of the federal law has been brought to our attention by hospitals that are "dumped on." Some officials of such hospitals are very reluctant to complain about associate hospitals who violate the law. Certain hospitals that are seen as the facilities of last resort are the regular recipients of repeated inappropriate transfers. However, even though the law permits them to bring a private right of action against the violators, political pressures usually prevent them from bringing such actions. Hospitals that are receiving inappropriate transfers are often in the same association with the hospitals that do the dumping and therefore hesitate to complain about their associates' behavior. A change in the law which requires hospitals and physicians to report violations of the law to the appropriate authorities would remove political considerations and enforcement would be enhanced.

Lastly, no matter how strong the laws are, they are virtually useless without administrative enforcement. From what we have seen so far, HHS enforcement of the COBRA statute has been extremely negligent. Three different branches of HHS are involved in various aspects of the enforcement effort. The branches are the Health Care Financing Administration, the Office of the Inspector General and the Office of Civil Rights. From the complainant's perspective it appears that coordination among the branches is non-existent. HCFA has delegated much of its responsibility to the states but has given the states almost no guidance on how to investigate complaints. Additionally, although the law was enacted in April, 1986 and went into effect almost a year ago on August 1, 1986, no proposed or final regulations have been promulgated. We really appreciate your interest in this problem, Congressman, and your willingness to question the agency on its activities in this regard.

The statute, if strengthened and enforced properly, can go a long way to solve the serious problem of people being denied emergency care because of their lack of ability to pay. The suggestions I have made for improvements would reenforce the individual's ability to receive and HHS's ability to assure access to care.

I would be derelict in my responsibility to my clients if I assured you, however, that a stronger federal law and enforcement would eradicate the "dumping" problem. I fear that some hospitals will continue to create new barriers to care and find new loopholes to avoid compliance with the spirit of the law. Many hospitals will go to great lengths to avoid providing care for people who have no insurance. The only sure way to end patient dumping is to guarantee that hospitals will get reimbursement for every individual who comes to their facility needing care.

Our health care system is based on payment to providers primarily through private insurance and government funded programs. Most Americans have such coverage. However, according to the Census Bureau, thirty-seven million men, women and children fall through the cracks of the health care system because they have no insurance coverage. Unfortunately for a variety of reasons the number is growing dramatically at a rate of about one million a year. In addition to the uninsured, over 50 million Americans were at risk of being unable to afford health care because of inadequate insurance.

Who are the uninsured? They are primarily workers and their families who have no insurance coverage through their work and have too much income to qualify for government programs. One-third of the uninsured are children and almost three quarters are members of families in which at least one member works full-time.

It is these uninsured people who are the least desirable to health care providers and who, as evidenced by the stories you have heard today, are at the highest risk of being "dumped." A recent study by the Robert Wood Johnson Foundation found that one million Americans were denied health care last year because they could not pay for it and an additional fourteen million did not seek the care they needed because they could not afford it.

The obvious solution to the patient dumping problem is to provide every American with health care coverage. Until everyone can guarantee payment for services, some providers will skirt or even violate the law to avoid serving uninsured patients and sadly "horror" stories such as the ones we heard today will continue to occur. Universal coverage would insure that every person gets crucial health care and patient dumping will become a practice of the past.

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July 20, 1987

The Honorable Ted Weiss
Committee on Government Operations
Subcommittee on Human Resources
  and Intergovernmental Relations
B372 Rayburn HOB
Washington, D.C. 20515

Re: COBRA Emergency Care Legislation

Dear Congressman Weiss:

As per your request, I have compiled the following list of suggested changes to the emergency room COBRA legislation. My suggestions are based on problems that advocates have brought to our attention.

In brief the suggestions are as follows:

-- Require that the appropriate transfer rules apply to all transfers

-- Require that rural tertiary hospitals accept emergency patients from other hospitals

-- Require that physicians who are "on call" to emergency rooms respond to calls regardless of the patient's ability to pay

-- Require that notice of this law be given to patients

-- Require that a "memorandum of transfer" be completed and sent with each transfer

-- Require hospitals that are "dumped on" to report the violations

-- Improve enforcement by requiring one division of HHS to investigate violations and enforce the statute

-- Improve enforcement by providing for attorneys' fees for individuals who are successful in enforcing the law

The following is a more detailed explanation of the suggestions:

Require That Appropriate Transfer Rules Apply to All Transfers

The statute currently allows hospitals to either stabilize or transfer the individual in question. As you told me, the original intent was to also require an appropriate transfer after the patient is stabilized. The following underlined changes in the statute would accomplish the original intent:

> "(b) NECESSARY STABILIZING TREATMENT FOR EMERGENCY CONDITIONS AND ACTIVE LABOR.--
>
> "(1) IN GENERAL.--If any individual (whether or not eligible for benefits under this title) comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide at a minimum either--
>
> "(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor, and/or
>
> "(B) for transfer of the individual to another medical facility in accordance with subsection (c).

Require That Rural Tertiary Hospitals Accept Emergency Patients From Other Hospitals

Two problems have surfaced in rural hospitals. The first is illustrated by the McAllen, Texas situation (see attached article) where a tertiary hospital established a blanket policy that it would not accept private pay or Medicaid transfers from the smaller hospitals in its area. The practical result of this policy was that when a small hospital called McAllen and was refused the right to transfer the patient, an uninsured teenager who had a bullet lodged in his brain, the receiving hospital told the family to take the boy on their own to McAllen's emergency room. McAllen could not then turn the boy away. The hospital finally sent the boy in an ambulance and his family followed in their car. He was ultimately admitted to McAllen but so much time had elapsed, he could not be saved.

Please consider a statutory change which would require tertiary hospitals in rural areas to accept patients from small, unequipped hospitals.

Require That Physicians Who Are "On Call to Emergency Rooms Respond to Calls Regardless of the Patient's Ability to Pay

Another problem in the rural area is addressed by a California bill which is now winding its way through the California legislature. This is the problem of the physician who is needed to treat the emergency condition, but will not come into the hospital because the patient is private pay.

The following is the language from the California bill. Perhaps it can be adapted for federal use.

> As a condition of licensure, each hospital shall require that, as a condition of staff privileges, physicians who serve on an "on-call" basis to the hospital's emergency room cannot refuse to respond to a call on the basis of the patient's...ability to pay for medical services....

Require That Notice of This Law Be Given to Patients

The California bill has three other provisions which you should consider because they would greatly enhance the effectiveness of the statute.

The first is requiring a notice to the public in each facility about their rights under this law. The California language is as follows:

> ...[a]ll hospitals will inform all persons presented to an emergency room or their representatives if any are present and the person is unable to understand verbal or written communication, both orally and in writing, of the reasons for the transfer or refusal to provide emergency services and care and of the person's right to emergency services and care prior to transfer or discharge without regard to ability to pay. Nothing in this subdivision requires notification of the reasons for the transfer in advance of the transfer where a person is unaccompanied and the hospital has made a reasonable effort to locate a representative, and because of the person's physical or mental condition, notification is not possible. All hospitals shall prominently post a sign in their emergency rooms informing the public of their rights. Both the posted sign and written communication concerning the transfer or refusal to provide emergency services and care shall give the address and phone number of the...government agency to contact in the event the person wishes to complain about the hospital's conduct.

Require That a "Memorandum of Transfer" Be Completed and Sent With Each Transfer

The other California section requires that a Memorandum of Transfer be completed and sent with each person who is transferred. This creates a record for the patients and the hospitals that are dumped on of all inappropriate transfers. I asked HCFA if they would consider putting this requirement in their regulations and was told that they would not do it because OMB would not approve it unless it was statutorily mandated. The following is California's proposed language:

> (f) The records transferred with the person include a "Memorandum of Transfer" signed by the transferring physician which contains relevant transfer information. The form of the "Memorandum of Transfer" shall, at a minimum, contain the person's name, address, sex, race, age, insurance status, and medical condition; the name and address of the transferring doctor or emergency room personnel authorizing the transfer; the time and date the person first presented at the transferring hospital; the name of the physician at the receiving hospital consenting to the transfer and the time and date of the consent; the time and date of the transfer; the reason for the transfer; and the declaration of the signor that the signor is assured, within reasonable medical probability, that the transfer creates no medical hazard to the patient. Neither the transferring physician nor transferring hospital shall be required to duplicate, in the "Memorandum of Transfer," information contained in medical records transferred with the person.

Require Hospitals That Are "Dumped On" to Report the Violations

Also the California bill requires each hospital that receives or physicians that know about inappropriate transfers to report such violations to the appropriate authorities. The reason for the requirement is to remove the political considerations from a facility's or doctor's decision on whether or not to report. The possibility of retribution for disclosure often prevents the disclosure from occurring. Since the law requires the report, the facility or physician has no choice but to provide the appropriate information.

Improve Enforcement by Requiring One Division of HHS (Preferably the Office of Inspector General) to Investigate Violations and Enforce the Statute

The last issue concerns enforcement. HCFA, as you know, has yet to issue proposed regulations. I understand that part of the problem is the hassle within the agency of getting HCFA and the Office of Inspector General (OIG) (each of which have responsibility under the statute) to coordinate their efforts. If they can't get together to decide on the regulations, I have grave doubts about their ability to coordinate enforcement.

As I understand it, the enforcement procedures are as follows:

HCFA has assigned the task of investigating complaints to the Office of Survey and Certification within the Health Standards and Quality Bureau. This office contracts with each state to perform certification reviews in nursing homes and hospitals that are not accredited by JCAH.

The state reviewers have some experience investigating complaints of violations of the conditions of participation. Their usual procedure, according to a HHS Central Office staffer, is to acknowledge receipt of the complaint and then investigate only those complaints where they have reason to believe a problem exists. Advocates for nursing home residents know their work because it is these agencies that investigate violations of the Medicaid and Medicare conditions of participation. Advocates have never been pleased with the timeliness or thoroughness of investigations.

Additionally, the state reviewers are severely handicapped right now because there are no regulations or official procedures to follow. Procedures for investigations will not be official until the final regulations are published. Probably few, if any, decisions will be issued until procedures and rules are final. Given the time frame for the rules, investigation procedures will not be in place until at least one year from now which will be close to two years after the law went into effect.

When the system is in place, it should work as follows. All complaints received by the Office of Inspector General (OIG) or HCFA Regional Offices will be referred to the state agencies. Complaints can be sent directly to the state. The state agency will investigate and refer to the Central Office of HCFA those cases the investigators think need enforcement actions. HCFA will decide whether to seek termination or suspension of the contract and will refer cases to the OIG which will then decide what, if any, actions for civil money penalties should be taken.

There are indications, however, that not all complaints will be investigated. HCFA is currently suggesting that only "flagrant" violations (undefined) or violations that show a pattern of abuse be investigated. Additionally, enforcement will no doubt vary dramatically around the country.

I do not know how OIG plans to coordinate its responsibility under the statute with HCFA. However, given the fact that HCFA will be coordinating with its regional offices and fifty one jurisdictions, coordination with OIG will no doubt result in painfully slow enforcement activities.

The Office of Civil Rights is also involved in the enforcement of emergency room requirements through its authority to enforce the Hill-Burton community service obligation. Currently, over half of the hospitals in this country have an obligation to provide emergency care regardless of the person's ability to pay. Any hospital that ever received Hill-Burton money retains this obligation.

It is unclear to us how OCR plans to coordinate its enforcement activities with OIG and HCFA. While the statutes they are charged with enforcing are not identical, they are close enough to require coordination.

Our experience has been that HHS enforcement is abysmal when only one division of the agency is charged with the responsibility. The current senario in which HCFA attempts to coordinate with OIG and OCR is, in my view, destined for disaster.

We appreciate your interest into examining the agency's activities and plans in this regard. I suggest that in order to streamline the agency process only one division of HHS be given enforcement responsibilities. Until we hear the testimony at your hearing, however, I am hesitant to suggest which division can do the best job.

Improve Enforcement by Providing for Attorneys' Fees for Individuals Who Are Successful in Enforcing the Law

Lastly, on the enforcement question, I would have to suggest that you think about the possibility of allowing private attorneys to collect attorneys' fees if they are successful in bringing private law suits to enforce the statute. I have received indications from private lawyers that they are reluctant to bring suits to make the hospital comply with the statute because unless their client has been severely physically harmed by the violation, there is no way the expenses or their fee will be paid. I am afraid that if HHS is not enforcing the statute and if private lawyers won't bring the cases, the law will become meaningless. Appropriate language to accomplish this goal is as follows:

> In any action or proceeding charging a violation of section 1867 of the Social Security Act, the court in its discretion may allow the individual or hospital harmed by the violation reasonable attorney's fee as part of the costs.

Thank you for considering these suggestions. I'm happy to discuss any or all of them with you.

Sincerely,

Judy Waxman
Judith G. Waxman
Managing Attorney

Mr. **Weiss**. Thank you, very much, Ms. Waxman.

Ms. Hill, tell us, if you will, what the reaction of your community, or your neighbors was after Mr. Takewell's death.

How did your neighbors in your community feel about the whole situation of Mr. Takewell, how he was treated and his death?

Ms. **Hill**. They felt like I did. They felt that he needed—they needed to keep him in the hospital; not let him come back home; not put him out.

They were angry, they were all upset like I was. They were upset.

Mr. **Weiss**. Thank you.

Ms. Waxman, how many other States have emergency room legislation? You mentioned a couple of them.

Ms. **Waxman**. Yes, there are about 21 States that do have some provision in their State statutes and a number of others that have regulatory provisions. But many of the laws are extremely broad. It has only been recently that States are starting to pass statutes that resemble the Federal statute.

About eight of them have new, stricter laws and five that have transfer rules, such as the ones in the Federal statutes.

Mr. **Weiss**. How about cities? Do any of the cities have local laws or ordinances that are similar to that legislation?

Ms. **Waxman**. Yes. A number of metropolitan areas are actually doing things that help quite a lot. They are getting all the hospitals together to develop protocols and procedures for transferring people.

One good example is Dallas where the public facility there, Parkland Memorial, has worked with other hospitals in the community. They have a 24-hour hot line which any hospital can call and describe the patient they want to transfer.

The hot line is staffed by a nurse who reviews the symptoms and so forth, talks to doctors and makes the decision to accept or refuse the transfer. This hot line speeds along the process and makes it more uniform. Also, the conversations on the hot line are tape recorded so there is a permanent record of every single conversation and every single transfer.

They have found that while there has been a great improvement in the number of inappropriate transfers—they feel there is about 90 percent compliance with their procedures—they still receive many stabilized patients who are transferred for economic reasons.

Also, a number of people still die shortly after arrival, but the situation has improved over what it used to be.

Mr. **Weiss**. Florida had a regional agreement among five or six hospitals for emergency treatment and care of patients. It broke down because apparently some of the hospitals felt that not all the other hospitals were taking their fair share, and the whole thing disintegrated. I think it underscores that you really need to have mutual agreements, that you need to have strong legislation at the State or Federal level.

What has been your experience with HHS on complaint investigations?

Ms. **Waxman**. As I stated in my testimony, lawyers hesitate to use the process. Under the COBRA statute, as far as I know, of the complaints that have been filed, no one has heard any response.

That is not correct. Someone recently did get a letter stating "we have received your complaint" and no other followup.

But mostly lawyers never hear back at all. Of course, our experience in the past with the agency, with OCR—and this committee has looked into that quite extensively, I know—has been that the processes are so extremely slow, even when one division of the agency must look at the problem. Lawyers just don't feel it is worth the bother to send in a complaint to the agency.

Mr. WEISS. Thank you. Mr. Green, I just want to comment that your friend was very lucky to have a friend as well versed and knowledgeable about the situation as you are. He may very well owe his life to you.

Mr. Lightfoot.

Mr. LIGHTFOOT. Thank you, Mr. Chairman. Mr. Green, I am curious, how is your friend?

Mr. GREEN. He is a lot better now. He was transferred to Kings County Hospital, a public hospital in Brooklyn. When he was released—actually, they tried to release him from the hospital—and we were really worried—before he was better. The staff in the hospital treated him really well. But the doctors complained throughout his stay, how does a 36-year old man have no insurance.

So he is being treated at Kings County Hospital in Brooklyn. Since then he has applied for Medicaid. He stayed in NYU for more than a month, and when he did arrive at Kings County Hospital in Brooklyn, one of the nurses kind of looked at him and said—how were you at NYU when you don't have any money or insurance?

He is starting to get better now.

Mr. LIGHTFOOT. If I interpreted your story correctly, you selected NYU because in your opinion they had a reputation for giving good service. But the problem was getting admitted to the hospital.

Not too many people would have thought to contact legal services, as you did. What caused you to do that?

Mr. GREEN. As I said before, I live in Brooklyn. Often—I don't know how many people are aware of it—there are a lot of people dying, and I see them dying from different illnesses, or cancer, or whatever it is. This has been going on for years. I think Margaret Heckler even wrote a report about it.

This is because people don't have insurance, and these are people who know that they cannot go to a hospital if they don't have the money. I think when people are really sick, the last thing on their mind is that they are dying. They just say, "Well, I am sick." To go to a doctor, you have to have at least $100 to $150 just to see a doctor.

To walk into an emergency room, even the worst ones in Brooklyn, you have to have $80 to $100, just to walk in the door. I think a lot of people know that they just can't go to a hospital.

I have seen it. My concern was not to be turned away because I felt if Iva went to the hospital when he was sick like this, and was turned away, his resort would not be even to try anymore; he would have stayed home and died.

That is why I called ahead of time to find out which hospitals would not turn me away by law. Some of them could just—for whatever reasons—just turn you away.

Mr. **Lightfoot**. You are aware of this just by the circumstances around you and you have observed this?

Mr. **Green**. I am aware of it for that reason, and over the years, different people I know had experiences where they were turned away. I see it happen all the time.

Also, I have to admit, it is one of the things I have always been worried about. A friend of mine told me if I got sick, my chances were better to get a $99 flight to London, where I would be treated in a hospital. It would come out cheaper than going to the emergency ward in most of the hospitals.

Mr. **Lightfoot**. Then if you get well, you would have a nice trip. I commend you for taking the initiative that you did. As Mr. Weiss said, you may very well have saved your friend's life.

I think you alluded to it; lack of information is one of the problems for people going to hospital emergency rooms. You mentioned that you didn't see any of the Hill-Burton information posted on the wall in the hospital. The fact that you knew enough and were aware enough of the situation that you did turn to legal services is noteworthy.

Do you have any ideas or recommendations on how other people in your community could be helped, so that they would be aware of that information and know those services are available to them?

Mr. **Green**. I think that information is needed. They are quick to give out information on things that sometimes we don't need. I remember in the past with things like food stamps, they would have announcements on television and the radio, if you needed help it was available. But when it came time to getting that help, no one knew how or they always acted like it is available but no one is coming to get it. There were tricky little laws, like you had to have a kitchen and you had to have this or that.

The same with this information. These programs are available and from what I understand, often the funds that they have aren't even used up. I can't believe for 1 minute that half of the people waiting at Bellvue, if they knew that they could go just three blocks away, to NYU's emergency room, if they knew that they would not be turned away, they would not do it.

I don't think NYU or half of the other hospitals in New York want it to be known that they don't have to turn people away.

They have contact with poor people. When they mail out checks to people or information to poor people, they could put that information right in that envelope. It wouldn't hurt. There are a lot of public service things that could be done which wouldn't take much money at all—just the letters that the Government mails out, they could put in information.

Those are just off my head, but it is definitely important that people know this. I would say statistically, if you look at the amount of people who are dying, they are not dying because they are that sick. The things that they often die from—for example, tuberculosis—I mean, Iva could have died from this, and it is something that is so treatable.

I think a high percentage of things that people really die from are easily treated, and if people know that, they could go and get the service.

Mr. Lightfoot. Ms. Waxman, you mentioned that Texas has a very strong State law. I lived there for about 6 years, and am somewhat familiar with the State. Do you know what motivated Texas to put that law in place? I don't.

Ms. Waxman. My understanding is that the Parkland Memorial Hospital, the major public facility in Texas, was faced with a very difficult situation of incredibly increased numbers of people being dumped on them, both unstable patients and patients in stable conditions. Parkland has a very strong administrator who made that fact known to the public, and then the legislature addressed the problem.

The administration in Texas also reviewed the law that they created and put into place some very good regulations.

Mr. Lightfoot. Are you relatively happy with it? If we are going to pick out a model law for other States to look at, would you recommend the Texas statute?

Ms. Waxman. I would also make some improvements to the Texas law. It goes farther than the Federal law, but there are a number of things that I think they are finding that would be improvements in their own law.

Interestingly enough, out of the 33 complaints that the HHS has received to date on the COBRA provision, I think 23 of them are from Texas. That indicates to me that the Texas law is working better than the Federal law in that either people know that it is there, or there is some attention to it so people know they can complain. Maybe it is the memo of transfer that I mentioned, or the recorded transfer information that allows people to be aware of the possible complaints.

It can't be a coincidence that so many of the complaints that even made it into the Federal agency have come from Texas. I think it has to have something to do with their State law.

Mr. Lightfoot. With the chairman's permission, and I am not trying to put you on the spot here—would you submit a letter to the committee with your recommendations on the Texas law and what improvements you would make to that so we would have it in writing?

Ms. Waxman. Yes, I will. Thank you for inviting me to do that.

[The letter follows:]

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October 21, 1987

Honorable Ted Weiss, Chair
Honorable Jim Lightfoot, Ranking
Minority Member
Committee on Government Operations
Human Resources and Intergovernmental Relations
Subcommittee
B372 Rayburn HOB
Washington, DC 20515

Dear Congressmen Weiss and Lightfoot:

Thank you so much for the opportunity to testify before your subcommittee on the subject of patient dumping. The hearing afforded the people who are concerned with the problem an excellent opportunity to explain the problem and the need for reform.

You asked me to make suggestions for changes in the federal law and to review the Texas law to determine what changes could improve that law also. The Texas statute was passed before the federal law and, and I understand it, served as model for it. Therefore, the same major provisions are in both laws. However Texas has written regulations which go beyond the statute to make some specific requirements on facilities. For example, Texas regulations provide that transfers "may not be predicated upon arbitrary, capricious or unreasonable discrimination based upon race, religion, national origin, age, sex, physical condition or economic status." Also, the regulations require that a "Memorandum of Transfer" containing pertinent information about the patient, his or her condition and the circumstances of the transfer be completed, signed by the transferring physician and sent with each patient who is transferred. HCFA has not as yet proposed regulations, but judging by what HCFA officials told you before the hearing, they are not proposing any requirements comparable to the Texas rules.

California has recently passed an "emergency room" statute which the Governor signed into law on September 27, 1987. It is more comprehensive than other state laws and may provide you with guidance for improvements in the federal law. I've attached it, in its entirety, for you.

At your request I have compiled a list of suggestions for improvements in the federal law. They are all based on problems that have been brought to my attention by lawyers from around the country whose clients have had difficulty obtaining emergency care. I have cited sections of the California law* to illustrate how one state dealt with a number of problems.

My suggestions are as follows:

1. Require That Appropriate Transfer Rules Apply to All Transfers

The statute currently allows hospitals to either stabilize or transfer the individual in question. The original intent was also to require an appropriate transfer after the patient is stabilized. The following underlined changes in the statute would accomplish the original intent:

> "(b) NECESSARY STABILIZING TREATMENT FOR EMERGENCY CONDITIONS AND ACTIVE LABOR.--
>
> "(1) IN GENERAL.--If any individual (whether or not eligible for benefits under this title) comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide at a minimum either--
>
> "(A) within the staff and facilities available at the hospital, for such further medical examination and such further medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor, and/or
>
> "(B) for transfer of the individual to another medical facility in accordance with subsection (c).

2. Include a Provision to Prohibit Discrimination in the Delivery of Emergency Services

The California statute, which is a good model, reads as follows:

> (b) In no event shall the provision of emergency services and care be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the individual.

* Printed at the end of this letter.

3. Require That Emergency Services Be Rendered Before the Person's Ability to Pay is Determined

We often hear of patients who must disclose their insurance status and ability to pay before they are physically screened to determine the extent of their physical condition. Many people complain that they are given a "wallet biopsy" before they get any care even in emergency situations. One way to prohibit this practice is to incorporate the following California provision:

> Emergency services and care shall be rendered without first questioning the patient or any other person as to his ability to pay therefor. However, the patient or his legally responsible relative or guardian shall execute an agreement to pay therefor or otherwise supply insurance or credit information promptly after the services are rendered.

4. Require That Rural Tertiary Hospitals Accept Emergency Patients From Other Hospitals

Two problems have surfaced in rural hospitals. The first is illustrated by the McAllen, Texas situation (see attached article) where a tertiary hospital established a blanket policy that it would not accept private pay or Medicaid transfers from the smaller hospitals in its area. The practical result of this policy was that when a small hospital call McAllen and was refused the right to transfer the patient, an uninsured teenager who had a bullet lodged in his brain, the receiving hospital told the family to take the boy on their own to McAllen's emergency room. McAllen could not then turn the boy away. The hospital finally sent the boy in an ambulance and his family followed in their car. He was ultimately admitted to McAllen but because so much time had elapsed, he could not be saved.

Please consider a statutory change which would require tertiary hospitals in rural areas to accept patients from small, unequipped hospitals.

5. Require That Physicians Who Are "On Call" to Emergency Rooms Respond to Calls Regardless of the Patient's Ability to Pay

Another problem in the rural area is the problem of the physician who is needed to treat the emergency condition, but will not come into the hospital because the patient has no insurance. We have heard from advocates who have complained that their clients have waited for hours unseen by any professional until a doctor comes to the hospital for his or her regular shift.

The following is California's solution to this problem:

> [E]ach hospital shall require that, as a condition of staff privileges, physicians who serve on an "on-call" basis to the hospital's emergency room cannot refuse to respond to a call on the basis of the patient's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the individual.

6. Require That Notice of This Law Be Given to Patients

Individuals do not know about their rights under the federal statute. This is evidenced by the fact that they do not refused inappropriate transfers, nor do they often complain to the authorities when their rights have been violated.

Again, California dealt with this problem with the following language:

> ...[a]ll hospitals will inform all persons presented to an emergency room or their representatives if any are present and the person is unable to understand verbal or written communication, both orally and in writing, of the reasons for the transfer or refusal to provide emergency services and care and of the person's right to emergency services and care prior to transfer or discharge without regard to ability to pay. Nothing in this subdivision requires notification of the reasons for the transfer in advance of the transfer where a person is unaccompanied and the hospital has made a reasonable effort to locate a representative, and because of the person's physical or mental condition, notification is not possible. All hospitals shall prominently post a sign in their emergency rooms informing the public of their rights. Both the posted sign and written communication concerning the transfer or refusal to provide emergency services and care shall give the address and phone number of the...government agency to contact in the event the person wishes to complain about the hospital's conduct.

7. Require That a "Memorandum of Transfer" Be Completed and Sent With Each Transfer

In order to assure that a record of each transfer is maintained, it is necessary to require that a "Memorandum of Transfer" or "Transfer Summary" be completed and sent with each person who is transferred. Such memos are the basis for data on all transfers and evidence for complaints by individuals and hospitals that are "dumped on." Texas includes this requirement in its regulations. The California statute requires the following:

> The records transferred with the person include a "Transfer Summary" signed by the transferring physician which contains relevant transfer information. The form of the "Transfer Summary" shall, at a minimum, contain the person's name, address, sex, race, age, insurance status, and medical condition; the name and address of the transferring doctor or emergency room personnel authorizing the transfer; the time and date the person was first presented at the transferring hospital; the name of the physician at the receiving hospital consenting to the transfer and the time and date of the consent; the time and date of the transfer; the reason for transfer; and the declaration of the transferring physician that the [benefit of the transfer outweighs the risk]. Neither the transferring physician nor transferring hospital shall be required to duplicate, in the "Transfer Summary," information contained in medical records transferred with the person.

8. Require That Records Be Maintained and Reported

To assure appropriate data collection, the California law requires that "[A]ll hospitals shall maintain records of each transfer made or received including the 'Memorandum of Transfer'...for a period of three years." Also California requires annual reports. The reports must include a description of "the aggregate number of transfers made and received according to the person's insurance status and reasons for transfer."

9. Require Hospitals That Are "Dumped On" to Report the Violations

Sometimes political considerations influence a facility's or doctor's decision to report or not report violations to the appropriate authorities. The possibility of retribution for disclosure often prevents the disclosure from occurring. If the law requires reporting, the facility or physician has no choice but to provide the appropriate information.

The California provision which addresses this problem is as follows:

> (c) The receiving hospital, and all physicians, other licensed emergency room health personnel at the receiving hospital, and certified prehospital emergency personnel who know of apparent violations of this article or the regulations adopted hereunder shall, and the corresponding personnel at the transferring hospital and the transferring hospital may, report the apparent violations to the state department on a form prescribed by the state department within one week following its occurrence.

I have not included excellent provisions which were suggested to you by other witnesses. Even so, my list is rather lengthy, and I hope comprehensive.

I am happy to discuss adapting these provisions for federal law or in making other revisions you deem appropriate. Thank you very much for the opportunity to provide you with my suggestions.

Sincerely,

Judy Waxman

Judith G. Waxman
Managing Attorney

Chapter 10[illegible] Statutes of 1987 Signed by the Governor 7/27/87

AMENDED IN SENATE SEPTEMBER 9, 1987

AMENDED IN SENATE SEPTEMBER 8, 1987

AMENDED IN SENATE SEPTEMBER 1, 1987

AMENDED IN SENATE AUGUST 17, 1987

AMENDED IN ASSEMBLY MAY 20, 1987

AMENDED IN ASSEMBLY MARCH 24, 1987

AMENDED IN ASSEMBLY FEBRUARY 13, 1987

CALIFORNIA LEGISLATURE—1987–88 REGULAR SESSION

ASSEMBLY BILL No. 214

Introduced by Assembly Member Margolin

January 7, 1987

An act to amend Sections 1317, 1798, 1798.170, 1798.172, 1798.206, and 1798.208 of, and to add Sections 1317.1, 1317.2, 1317.2a, 1317.3, 1317.4, 1317.5, 1317.6, 1317.7, 1317.8, 1317.9, 1317.9a, and 1798.205 to, the Health and Safety Code, relating to hospital emergency medical treatment and patient transfer.

LEGISLATIVE COUNSEL'S DIGEST

AB 214, as amended, Margolin. Hospital emergency patient transfers.

Various provisions of existing law regulate hospitals and the treatment of patients.

This bill would regulate the treatment of patients brought to hospital emergency rooms and the transfer of those patients to other medical facilities. It would prohibit basing an emergency patient's treatment on the patient's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, unless the circumstances are medically significant to the provision of appropriate medical care to that individual. The bill would revise the definition of "emergency services and care" and "medical hazard" and define *"consultation" and* "within the capability of the facility." It would specify conditions under which emergency medical patients may be transferred and procedures which may be followed.

The bill would specify under what conditions a hospital is obligated to accept the transfer of a patient, and would require a hospital that is unable to accept the transfer of a patient for whom it is legally or contractually liable, to make arrangements for the patient's care. The bill would require receiving hospitals which do not accept transfers of, or make other appropriate arrangements for, certain medically stable patients for which they are contractually or statutorily obligated to provide care, to be liable, as specified.

The bill would require hospitals to adopt policies and transfer protocols consistent with the bill and a hospital's compliance with specified procedures would be a condition of licensure or revocation thereof. Violators could also be fined, as specified, for hospital violations, and taking into account certain factors or have their emergency medical service permits revoked. This bill would also create certain civil actions, as specified, and exempt the health facility and specified health professionals from liability for refusing to render emergency services under certain circumstances. The receiving hospital, and physicians, emergency room health personnel at the receiving hospital, and certified prehospital emergency personnel would be required to report all apparent violations known to them to the State Department of Health Services for investigation. The bill would provide that a physician shall not be prevented from exercising professional judgment in conflict with certain state and local regulations under specified circumstances.

Local emergency medical services agencies would also be obligated to mandate transfer protocols, guidelines, and agreements, as specified. These requirements would impose a state-mandated local program on these agencies.

This bill would create new misdemeanors, thus imposing

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new duties upon local law enforcement agencies, thereby constituting a state-mandated local program.

This bill would also provide that the Governor shall request the federal government to credit certain monetary penalties against subsequent penalties assessed by the federal government and require the department to take certain actions to ensure that a specified cumulative maximum limit of fines assessed under state and federal law is not exceeded.

Under existing law, the medical direction and management of an emergency medical services system on the local level is under the control of the medical director of the local emergency medical services agency.

This bill would establish procedures for the medical director of a base station who questions the medical effect of a policy of a local emergency medical services agency to have a hearing on the matter.

This hearing procedure would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates which do not exceed $500,000 statewide and other procedures for claims whose statewide costs exceed $500,000.

This bill would provide that for certain costs no reimbursement is required by this act for a specified reason.

Moreover, the bill would provide that no reimbursement shall be made from the State Mandates Claims Fund for other costs mandated by the state pursuant to this act, but would recognize that local agencies and school districts may pursue any available remedies to seek reimbursement for those other costs.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1317 of the Health and Safety Code is amended to read:

1317. (a) Emergency services and care shall be provided to any person requesting services or care, or for whom services or care is requested, for any condition in which the person is in danger of loss of life, or serious injury or illness, at any health facility licensed under this chapter that maintains and operates an emergency department to provide emergency services to the public when the health facility has appropriate facilities and qualified personnel available to provide the services or care.

(b) In no event shall the provision of emergency services and care be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to that individual.

(c) Neither the health facility, its employees, nor any physician, dentist, or podiatrist shall be held liable in any action arising out of a refusal to render emergency services or care if reasonable care is exercised in determining and treating the condition of the person, or in determining the appropriateness of the facilities, the qualifications and availability of personnel to render the services.

(d) Emergency services and care shall be rendered without first questioning the patient or any other person as to his ability to pay therefor. However, the patient or his legally responsible relative or guardian shall execute an agreement to pay therefor or otherwise supply insurance or credit information promptly after the services are rendered.

(e) If a health facility subject to this chapter does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency exists and shall direct the persons seeking emergency care to a nearby facility which can render the needed services, and shall assist the persons seeking emergency care in obtaining the services, including transportation services, in every way reasonable under the circumstances.

(f) No act or omission of any rescue team established by any health facility licensed under this chapter, or operated by the federal or state government, a county, or by the Regents of the University of California, done or omitted while attempting to resuscitate any person who is in immediate danger of loss of life shall impose any liability upon the health facility, the officers, members of the staff, nurses, or employees of the health facility, including, but not limited to, the members of the rescue team, or upon the federal or state government or a county, if good faith is exercised.

(g) "Rescue team," as used in this section, means a special group of physicians and surgeons, nurses, and employees of a health facility who have been trained in cardiopulmonary resuscitation and have been designated by the health facility to attempt, in cases of emergency, to resuscitate persons who are in immediate danger of loss of life.

(h) This section shall not relieve a health facility of any duty otherwise imposed by law upon the health facility for the designation and training of members of a rescue team or for the provision or maintenance of equipment to be used by a rescue team.

SEC. 2. Section 1317.1 is added to the Health and Safety Code, to read:

1317.1. Unless the context otherwise requires, the following definitions shall control the construction of this article:

(a) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

(b) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Placing the patient's health in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

(c) "Active labor" means a labor at a time at which either of the following would occur:

(1) There is inadequate time to effect safe transfer to another hospital prior to delivery.

(2) A transfer may pose a threat to the health and safety of the patient or the unborn child.

(d) "Hospital" means all hospitals with an emergency department licensed by the state department.

(e) "State department" means the State Department of Health Services.

(f) "Medical hazard" means a material deterioration in medical condition in, or jeopardy to, a patients' medical condition or expected chances for recovery.

(g) "Board" means the Board of Medical Quality Assurance.

(h) "Within the capability of the facility" means those capabilities which the hospital is required to have as a condition of its emergency medical services permit and services specified on Services Inventory Form 7041 filed by the hospital with the Office of Statewide Health Planning and Development.

(i) "Consultation" means the rendering of an opinion, advice, or prescribing treatment by telephone and, when determined to be medically necessary jointly by the emergency and specialty physicians, includes review of the patient's medical record, examination, and treatment of the patient in person by a specialty physician who is

qualified to give an opinion or render the necessary treatment in order to stabilize the patient.

SEC. 3. Section 1317.2 is added to the Health and Safety Code, to read:

1317.2. No person needing emergency services and care may be transferred from a hospital to another hospital for any nonmedical reason (such as the person's inability to pay for any emergency service or care) unless each of the following conditions are met:

(a) The person is examined and evaluated by a physician *including, if necessary, consultation* prior to transfer.

(b) The person has been provided with emergency services and care such that it can be determined, within reasonable medical probability, that the transfer or delay caused by the transfer will not create a medical hazard to the person.

(c) A physician at the transferring hospital has notified and has obtained the consent to the transfer by a physician at the receiving hospital and confirmation by the receiving hospital that the person meets the hospital's admissions criteria relating to appropriate bed, personnel, and equipment necessary to treat the person.

(d) The transferring hospital provides appropriate personnel and equipment which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use to effect the transfer.

(e) All the person's pertinent medical records and copies of all the appropriate diagnostic test results which are reasonably available are transferred with the person.

(f) The records transferred with the person include a "Transfer Summary" signed by the transferring physician which contains relevant transfer information. The form of the "Transfer Summary" shall, at a minimum, contain the person's name, address, sex, race, age, insurance status, and medical condition; the name and address of the transferring doctor or emergency room personnel authorizing the transfer; the time and date the person was first presented at the transferring hospital; the name of the physician at the receiving hospital consenting to the transfer and the time and date of the consent; the time and date of the transfer; the reason for the transfer; and the declaration of the transferring physician that the transferring physician is assured, within reasonable medical probability, that the transfer creates no medical hazard to the patient. Neither the transferring physician nor transferring hospital shall be required to duplicate, in the "Transfer Summary," information contained in medical records transferred with the person.

(g) The transfer conforms with regulations established by the state department. These regulations may prescribe minimum protocols for patient transfers.

(h) Nothing in this section shall apply to a transfer of a patient for medical reasons.

(i) Nothing in this section shall prohibit the transfer or discharge of a patient when the patient or the patient's representative requests a transfer or discharge and gives informed consent to the transfer or discharge against medical advice.

SEC. 4. Section 1317.2a is added to the Health and Safety Code, to read:

1317.2a. (a) A hospital which has a legal obligation, whether imposed by statute or by contract to the extent of that contractual obligation, to any third-party payor, including, but not limited to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, or preferred provider organization, a county, or an employer to provide care for a patient under the circumstances specified in Section 1317.2 shall receive that patient to the extent required by the applicable statute or by the terms of the contract, or, when the hospital is unable to accept a patient for whom it has a legal obligation to provide care whose transfer will not create a medical hazard as specified in Section 1317.2, it shall make appropriate arrangements for the patient's care.

(b) A county hospital shall accept a patient whose transfer will not create a medical hazard as specified in subdivision (b) of Section 1317.2 and who is determined

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by the county to be eligible to receive health care services required under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code, unless the hospital does not have appropriate bed capacity, medical personnel, or equipment required to provide care to the patient in accordance with accepted medical practice. When a county hospital is unable for any of these reasons to accept a patient whose transfer will not create a medical hazard as specified in subdivision (b) of Section 1317.2, it shall make appropriate arrangements for the patient's care. The obligation to make appropriate arrangements does not mandate a level of service or payment, does not modify the county's obligations under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code, and does not create a cause of action or limit a county's flexibility to manage county health systems within available resources, but this flexibility shall not diminish a county's responsibilities under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code or the requirements contained in Chapter 2.5 (commencing with Section 1440).

(c) When a patient is transferred pursuant to subdivision (a), the receiving hospital shall provide personnel and equipment reasonably required in the exercise of good medical practice for the care of the transferred patient.

(d) Any third-party payor, including, but not limited to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, preferred provider organization, or employer which has a statutory or contractual obligation to provide or indemnify emergency medical services on behalf of a patient shall be liable, to the extent of the contractual obligation, for the reasonable charges of the transferring hospital and the treating physicians for the emergency services provided pursuant to this article, except that the patient shall be responsible for any deductible or copayment obligation. Notwithstanding this section, the liability of a third-party payor which has contracted with health care providers for the provision of these emergency services shall be set by the terms of that contract. Notwithstanding this section, the liability of a third-party payor that is licensed by the Insurance Commissioner or the Commissioner of Corporations and has a contractual obligation to provide or indemnify emergency medical services shall be determined in accordance with the terms of that contract and shall remain under the sole jurisdiction of that licensing agency.

(e) A hospital which has a legal obligation to provide care for a patient as specified by subdivision (a) of Section 1317.2a, to the extent of its legal obligation imposed by statute or by contract to the extent of that contractual obligation and which does not accept transfer of, or make other appropriate arrangements for medically stable patients in violation of this article or regulations adopted pursuant thereto shall be liable for the reasonable charges of the transferring hospital and treating physician for providing services and care which should have been provided by the receiving hospital.

(f) Subdivisions (d) and (e) do not apply to county obligations under Section 17000 of the Welfare and Instutitions Code.

(g) Nothing in this section shall be interpreted to require a hospital to make arrangements for the care of a patient for whom the hospital does not have a legal obligation to provide care.

SEC. 5. Section 1317.3 is added to the Health and Safety Code, to read:

1317.3. (a) As a condition of licensure, each hospital shall adopt, in consultation with the medical staff, policies and transfer protocols consistent with this article and regulations adopted hereunder.

(b) As a condition of licensure, each hospital shall adopt a policy prohibiting discrimination in the provision of emergency services and care based on race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to that individual.

(c) As a condition of licensure, each hospital shall require that, as a condition of staff privileges, physicians who serve on an "on-call" basis to the hospital's emergency room cannot refuse to respond to a call on the basis of the patient's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to that individual. If a contract between a physician and hospital for the provision of emergency room coverage presently prevents the hospital from imposing those conditions, the conditions shall be included in the contract as soon as is legally permissible. Nothing in this section shall be construed as requiring that any physician serve on an "on call" basis.

(d) As a condition of licensure, all hospitals will inform all persons presented to an emergency room or their representatives if any are present and the person is unable to understand verbal or written communication, both orally and in writing, of the reasons for the transfer or refusal to provide emergency services and care and of the person's right to emergency services and care prior to transfer or discharge without regard to ability to pay. Nothing in this subdivision requires notification of the reasons for the transfer in advance of the transfer where a person is unaccompanied and the hospital has made a reasonable effort to locate a representative, and because of the person's physical or mental condition, notification is not possible. All hospitals shall prominently post a sign in their emergency rooms informing the public of their rights. Both the posted sign and written communication

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concerning the transfer or refusal to provide emergenc services and care shall give the address of the stat department as the government agency to contact in th event the person wishes to complain about the hospital conduct.

(e) If a hospital does not timely adopt the policies an protocols required in this article, the hospital, in additic to denial or revocation of any of its licenses, shall l subject to a fine not to exceed one thousand dolla ($1,000) each day after expiration of 60 days' writte notice from the state department that the hospital policies or protocols required by this article ai inadequate unless the delay is excused by the stat department upon a showing of good and sufficient cau by the hospital. The notice shall include a detail statement of the state department's reasons for i determination and suggested changes to the hospita protocols which would be acceptable to the sta department.

(f) Each hospital's policies and protocols required or under this article shall be submitted for approval to tl state department within 90 days of the state departmen adoption of regulations under this article.

SEC. 6. Section 1317.4 is added to the Health ai Safety Code, to read:

1317.4. (a) All hospitals shall maintain records each transfer made or received, including tl "Memorandum of Transfer" described in subdivision (of Section 1317.2, for a period of three years.

(b) All hospitals making or receiving transfers shall f with the state department annual reports on fori prescribed by the state department which shall descril the aggregate number of transfers made and receiv according to the person's insurance status and reasons f transfers.

(c) The receiving hospital, and all physicians, oth licensed emergency room health personnel at tl receiving hospital, and certified prehospital emergen personnel who know of apparent violations of this artic or the regulations adopted hereunder shall, and tl corresponding personnel at the transferring hospital and the transferring hospital may, report the apparent violations to the state department on a form prescribed by the state department within one week following its occurrence. The state department shall promptly send a copy of the form to the hospital administrator and appropriate medical staff committee of the transferring hospital and the local emergency medical services agency *unless the state department concludes that the complaint does not allege facts requiring further investigation, or is otherwise unmeritorious, or the state department concludes, based upon the circumstance of the case, that its investigation of the allegations would be impeded by disclosure of the form*. When two or more persons required to report jointly have knowledge of an apparent violation, a single report may be made by a member of the team selected by mutual agreement in accordance with hospital protocols. Any individual, required to report by this section, who disagrees with the proposed joint report has a right and duty to separately report. A failure to report shall not subject the individual or institution to the penalties set forth in Section 1317.6.

(d) No hospital, government agency, or person shall retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to a physician or other personnel for reporting in good faith an apparent violation of this article or the regulations adopted hereunder to the state department, hospital, medical staff, or any other interested party or government agency.

(e) No hospital, government agency, or person shall retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to a physician who refused to transfer a patient when the physician determines, within reasonable medical probability, that the transfer, or delay caused by the transfer, will create a medical hazard to the person.

(f) Any person who violates subdivision (d) or (e) is subject to a civil money penalty of no more than ten thousand dollars ($10,000). The remedy specified in this section shall be in addition to any other remedy provided by law.

(g) The state department shall on an annual basis publish and provide to the Legislature a statistical summary by county on the extent of economic transfers of emergency patients, the frequency of medically hazardous transfers, the insurance status of the patient populations being transferred and all violations finally determined by the state department describing the nature of the violations, hospitals involved, and the action taken by the state department in response. These summaries shall not reveal the identity of individual persons transferred.

(h) Proceedings by the state department to impose a fine under Section 1317.3 or 1317.6, and proceedings by the board to impose a fine under Section 1317.6, shall be ~~conducted in accordance with the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.~~ *conducted as follows:*

(1) If a hospital desires to contest a proposed fine, the hospital shall, within 15 business days after service of the notice of proposed fine, notify the director in writing of its intention to contest the proposed fine. If requested by the hospital, the director or the director's designee, shall hold, within 30 business days, an informal conference, at the conclusion of which he or she may affirm, modify, or dismiss the proposed fine. If the director or the director's designee affirms, modifies, or dismisses the proposed fine, he or she shall state with particularity in writing his or her reasons for that action, and shall immediately transmit a copy thereof to the hospital. If the hospital desires to contest a determination, the hospital shall inform the director in writing within 15 business days after it receives the decision by the director or director's designee. The hospital shall not be required to request an informal conference to contest a proposed fine as provided in this section. If the hospital fails to notify the director in writing that it intends to protest the proposed fine within the times specified in this subdivision, the

proposed fine shall be deemed a final order of the state department and shall not be subject to further administrative review.

(2) If a hospital notifies the director that it intends to contest a proposed fine, the director shall immediately notify the Attorney General. Upon notification, the Attorney General shall promptly take all appropriate action to enforce the proposed fine in a court of competent jurisdiction for the county in which the hospital is located.

(3) If a judicial proceeding is prosecuted under the provisions of this section, the state department shall have the burden of establishing by a preponderance of the evidence that the alleged facts supporting the proposed fine occurred, that the alleged facts constituted a violation for which a fine may be assessed under Section 1317.3, 1317.4, or 1317.6, and that the proposed fine is appropriate. The state department shall also have the burden of establishing by a preponderance of the evidence that on appeal the assessment of the proposed fine would be upheld. If a hospital timely notifies the state department of its decision to contest a proposed fine, the fine shall not be due and payable unless and until the judicial proceeding is terminated in favor of the state department.

(4) Actions brought under the provisions of this section shall be set for trial at the earliest possible date and shall take precedence on the court calendar over all other cases except matters to which equal or superior precedence is specifically granted by law. Times for responsive pleading and for hearing the proceeding shall be set by the judge of the court with the object of securing a decision as to subject matters at the earliest possible time.

(5) If the proposed fine is dismissed or reduced, the state department shall take action immediately to ensure that the public records reflect in a prominent manner that the proposed fine was dismissed or reduced.

(6) In lieu of a judicial proceeding, the state department and the hospital may jointly elect to submit

the matter to binding arbitration. The parties shall agree upon an arbitrator designated from the American Arbitration Association in accordance with the association's established rules and procedures. The arbitration hearing shall be set within 45 days of the parties' joint election, but in no event less than 28 days from the date of selection of an arbitrator. The arbitrator hearing may be continued up to 15 days if necessary at the arbitrator's discretion. The decision of the arbitrator shall be based upon substantive law and shall be binding on all parties, subject to judicial review. This review shall be limited to whether there was substantial evidence to support the decision of the arbitrator.

(7) Proceedings by the board to impose a fine under Section 1317.6, shall be conducted in accordance with the provisions of Chapter 5 (commencing with Section 11500) of Part 2 of Division 3 of Title 2 of the Government Code.

SEC. 7. Section 1317.5 is added to the Health and Safety Code, to read:

1317.5. (a) All alleged violations of this article and the regulations adopted hereunder shall be investigated by the state department. The state department, with the agreement of the local EMS agency, may refer violations of this article to the local EMS agency for investigation. The investigation shall be conducted pursuant to procedures established by the state department and shall be completed no later than 60 days after the report of apparent violation is received by the state department.

(b) At the conclusion of its investigation, the state department or the local EMS agency shall refer any alleged violation by a physician to a board of medical quality assurance unless it is determined that the complaint is without a reasonable basis.

SEC. 8. Section 1317.6 is added to the Health and Safety Code, to read:

1317.6. (a) Hospitals found by the state department to have committed, or to be responsible for, a violation of the provisions of this article or the regulations adopted hereunder may each be fined by the state department in an amount not to exceed twenty-five thousand dollars ($25,000) for each hospital violation. However, with respect to licensed physicians, the board shall have sole authority to impose a fine. Fines imposed under this section shall not be cumulative.

(1) In determining the amount of the fine for a hospital violation, the state department shall take into account all of the following:

(A) Whether the violation was knowing or unintentional.

(B) Whether the violation resulted, or was reasonably likely to result, in a medical hazard to the patient.

(C) The frequency or gravity of the violation.

(D) Other civil fines which have been imposed as a result of the violation under Section 1867 of the federal Social Security Act.

It is the intent of the Legislature that the state department has primary responsibility for regulating the conduct of hospital emergency rooms and that fines imposed under this section should not be duplicated by additional fines imposed by the federal government as a result of the conduct which constituted a violation of this section. To effectuate the Legislature's intent, the Governor shall inform the Secretary of the federal Department of Health and Human Services of the enactment of this section and request the federal department to credit any penalty assessed under this section against any subsequent civil monetary penalty assessed pursuant to Section 1867 of the federal Social Security Act for the same violation.

(2) Physicians found by the board to have committed, or to be responsible for, a violation of this article or the regulations adopted pursuant thereto are subject to any and all penalties which the board may lawfully impose and may be fined by the board in an amount not to exceed five thousand dollars ($5,000) for each violation. The board may impose fines when it finds any of the following:

(A) The violation was knowing or willful.

(B) The violation was reasonably likely to result in a medical hazard.

(C) There are repeated violations.

The board shall take into account all of these factors when determining the amount of the fine. Fines imposed under this paragraph shall not duplicate federal fines, and the board shall credit any federal fine against fines imposed under this paragraph.

(3) There shall be a cumulative maximum limit of thirty thousand dollars ($30,000) in fines assessed against either physicians or hospitals under this article and under Section 1867 of the federal Social Security Act for the same circumstances. To effectuate this cumulative maximum limit, the state department shall do both of the following:

(A) As to state fines assessed prior to the final conclusion, including judicial review, if available, of an action against a hospital by the federal Department of Health and Human Services under Section 1867 of the federal Social Security Act, (for the same circumstances finally deemed to have been a violation of this article or the regulations adopted hereunder, because of the state department action authorized by this article), remit and return to the hospital within 30 days after conclusion of the federal action, that portion of the state fine necessary to assure that the cumulative maximum limit is not exceeded.

(B) Immediately credit against state fines assessed after the final conclusion, including judicial review, if available, of an action against a hospital by the federal Department of Health and Human Services under Section 1867 of the federal Social Security Act, which results in a fine against a hospital (for the same circumstances finally deemed to have been a violation of this article or the regulations adopted hereunder, because of the state department action authorized by this article), the amount of the federal fine necessary to assure the cumulative maximum limit is not exceeded.

(b) Any hospital found by the state department pursuant to procedures established by the state department to have committed a violation of this article or the regulations adopted hereunder may have its emergency medical service permit revoked or suspended by the state department.

(c) Any administrative or medical personnel who knowingly and intentionally violates any provision of this article, may be charged by the local district attorney with a misdemeanor.

(d) The penalties listed in subdiviions (a), (b), and (c), shall only be applied for violations of Section 1317, 1317.1, or 1317.2.

(e) Notification of each violation found by the state department of the provisions of this article or the regulations adopted hereunder shall be sent by the state department to the Joint Commission for the Accreditation of Hospitals, and state and local emergency medical services agencies.

(f) Any person who suffers personal harm and any medical facility which suffers a financial loss as a result of a violation of this article or the regulations adopted hereunder may recover, in a civil action against the transferring hospital or responsible administrative or medical personnel, damages, reasonable attorneys' fees, and other appropriate relief. Transferring hospitals from which inappropriate transfers of persons are made in violation of this article and the regulations adopted hereunder shall be liable for the normal charges of the receiving hospital for providing the emergency services and care which should have been provided before transfer. Any person potentially harmed by a violation of this article or the regulations adopted hereunder, or the local district attorney or the Attorney General, may bring a civil action against the responsible hospital or administrative or medical personnel, to enjoin the violation, and if the injunction issues, a court shall award reasonable attorney's fees. The provisions of this subdivision are in addition to other civil remedies and do not limit the availability of the other remedies.

(g) Neither the health facility, its employees, nor any physician, dentist, or podiatrist shall be liable in any action arising out of a refusal to render emergency services or care if the refusal is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition, or that the health facility does not have the appropriate facilities or qualified personnel available to render those services.

SEC. 9. Section 1317.7 is added to the Health and Safety Code, to read:

1317.7. This article shall not preempt any governmental agencies, acting within their authority, from regulating emergency care or patient transfers, including the imposition of more specific duties consistent with the requirements of this article and its implementing regulations. Any inconsistent requirements imposed by the Medi-Cal program shall preempt the provisions of this article with respect to Medi-Cal beneficiaries. To the extent hospitals and physicians enter into contractual relationships with governmental agencies which impose more stringent transfer requirements, those contractual agreements shall control.

SEC. 10. Section 1317.8 is added to the Health and Safety Code, to read:

1317.8. If any provision of this article is declared unlawful or unconstitutional in any judicial action, the remaining provisions of this chapter shall remain in effect.

SEC. 11. Section 1317.9 is added to the Health and Safety Code, to read:

1317.9. The state department shall adopt on an emergency basis regulations to implement the provisions of this article by July 1, 1989.

SEC. 12. Section 1317.9a is added to the Health and Safety Code, to read:

1317.9a. This article shall not be construed as repealing Section 2400 of the Business and Professions Code. Nothing in Sections 1317 to 1317.9a, inclusive, and Section 1798.170 shall prevent a physician from exercising his or her professional judgment in conflict with any state or local regulation promulgated under these sections, so

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long as the judgment conforms with Sections 1317, 1317.1, and 1317.2, except for subdivision (g) of Section 1317.2, ~~and is made in the best interests of medical treatment for the patient~~ *and acting in compliance with the state or local regulations would be contrary to the best interests of the patient.*

SEC. 13. Section 1798 of the Health and Safety Code is amended to read:

1798. (a) The medical direction and management of an emergency medical services system shall be under the medical control of the medical director of the local EMS agency. This medical control shall be maintained in the following manner:

(1) Prospectively by written medical policies and procedures to provide standards for patient care.

(2) Immediately by direct voice communication between a certified EMT-P or EMT-II and a base hospital emergency physician or an authorized registered nurse and, in the event of temporary unavailability of voice communications, by utilization by an EMT-P or EMT-II of authorized, written orders and policies established pursuant to Section 1798.4.

(3) Retrospectively by means of medical audit of field care and continuing education.

(b) Medical control shall be within an EMS system which complies with the minimum standards adopted by the authority, and which is established and implemented by the local EMS agency.

(c) In the event a medical director of a base station questions the medical effect of a policy of a local EMS agency, the medical director of the base station shall submit a written statement to the medical director of the local EMS agency requesting a review by a panel of medical directors of other base stations. ~~Upon receipt of the request, the medical director of a local EMS agency shall immediately convene a panel of medical directors of other base stations.~~ Upon receipt of the request, the medical director of a local EMS agency shall ~~within 30 days~~ *promptly* convene a panel of medical directors of base stations to evaluate the written statement. The panel shall be composed of all the medical directors of the base stations in the region, except that the local EMS medical director may limit the panel to five members.

This subdivision shall be operative only until the authority adopts more comprehensive regulations that supersede this subdivision.

SEC. 14. Section 1798.170 of the Health and Safety Code is amended to read:

1798.170. A local EMS agency may develop triage and transfer protocols to facilitate prompt delivery of patients to appropriate designated facilities within and without its area of jurisdiction. Considerations in designating a facility shall include, but shall not be limited to, the following:

(a) A general acute care hospital's consistent ability to provide on-call physicians and services for all emergency patients regardless of ability to pay.

(b) The sufficiency of hospital procedures to ensure that all patients who come to the emergency department are examined and evaluated to determine whether or not an emergency condition exists.

(c) The hospital's compliance with local EMS protocols, guidelines, and transfer agreement requirements.

SEC. 15. Section 1798.172 of the Health and Safety Code is amended to read:

1798.172. (a) The local EMS agency shall establish guidelines and standards for completion and operation of formal transfer agreements between hospitals with varying levels of care in the area of jurisdiction of the local EMS agency, consistent with Sections 1317 to 1317.9a, inclusive, and Section 1798. Each local EMS agency shall solicit and consider public comment in drafting guidelines and standards. These guidelines shall include provision for suggested written agreements for the type of patient, necessary initial care treatments, requirements of interhospital care, and associated logistics for transfer, evaluation, and monitoring of the patient.

(b) Notwithstanding the provisions of subdivision (a), and in addition to the provisions of Section 1317, a general acute care hospital licensed under Chapter 2 (commencing with Section 1250) of Division 2 shall not transfer a person for nonmedical reasons to another health facility unless that other facility receiving the person agrees in advance of the transfer to accept the transfer. ~~Draft guidelines and standards shall be the subject of a public hearing.~~

SEC. 16. Section 1798.205 is added to the Health and Safety Code, to read:

1798.205. Any alleged violations of local EMS agency transfer protocols, guidelines, or agreements ~~shall be investigated by the local EMS agency. The investigation shall be completed within 60 days after the apparent violation is reported. If the local EMS agency~~ *shall be evaluated by the local EMS agency. If the local EMS agency* has concluded that a violation has occurred, it shall take whatever corrective action it deems appropriate within its jurisdiction, including referrals to the district attorney under Sections 1798.206 and 1798.208, and shall notify the State Department of Health Services that a violation of Sections 1317 to 1317.9a, inclusive, has occurred.

SEC. 17. Section 1798.206 of the Health and Safety Code is amended to read:

1798.206. Any person who violates this part, the rules and regulations adopted pursuant thereto, or county ordinances adopted pursuant to this part governing patient transfers, is guilty of a misdemeanor. The Attorney General or the district attorney may prosecute any of these misdemeanors which falls within his or her jurisdiction.

SEC. 18. Section 1798.208 of the Health and Safety Code is amended to read:

1798.208. Whenever any person who has engaged, or is about to engage, in any act or practice which constitutes, or will constitute, a violation of this part, the rules and regulations promulgated pursuant thereto, or local EMS agency protocols, guidelines, or transfer agreements mandated by the state, the superior court in and for the county wherein the acts or practices take place or are about to take place may issue an injunction or other appropriate order restraining that conduct on application of the authority, the Attorney General, or the district attorney of the county. The proceedings under this section shall be governed by Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure, except that no undertaking shall be required.

SEC. 19. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for those costs which may be incurred by a local agency or school district because this act creates a new crime or infraction, changes the definition of a crime or infraction, changes the penalty for a crime or infraction, or eliminates a crime or infraction.

Moreover, no reimbursement shall be made from the State Mandates Claims Fund pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code for other costs mandated by the state pursuant to this act. It is recognized, however, that a local agency or school district may pursue any remedies to obtain reimbursement available to it under Part 7 (commencing with Section 17500) and any other provisions of law for those other costs.

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Mr. Lightfoot. I thank all three of you for coming.

Mr. Weiss. Mr. Sawyer.

Mr. Sawyer. Thank you, Mr. Chairman. Clearly you describe a circumstance where the existing Federal law is apparently insufficient to deal with the problem. It seems almost silly to me, but I want to ask this question anyway. Whatever happened to the ethical standards of the professions that we now find have to be pressed into compliance by force of law? Do they have no bearing in the treatment of patients anymore?

Ms. Waxman. I am afraid I cannot answer that. You will have to ask the doctors that question.

Mr. Weiss. The following panel will have some medical professionals on it.

Mr. Sawyer. A second question that perhaps goes more to your profession. The chairman mentioned the State of Florida, where I was a couple of weeks ago at a hearing, in which there has been reported a pattern of dumping that was the product of a perceived absence of liability coverage in emergency rooms.

Has there been a pattern of litigation, not so much over the matter of mistreatment, but over the matter of nontreatment; and are hospitals and their administrations and their physicians liable for failure to treat? Is there a duty or obligation to deal with the patient as they come before them, under even the most general kinds of statutes.

Ms. Waxman. Well, certainly there are common law requirements that facilities treat patients, and the COBRA law does allow for a private right of action against hospitals. Therefore, an individual who is harmed in this situation can directly sue the facility.

The Federal law does allow, as I said, hospitals who are dumped on to sue, but we haven't seen that provision actually being used.

Mr. Sawyer. I understand the problem that you described was the relationship among hospitals within a community. But I am surprised that there have not been more individual actions.

Ms. Waxman. I think it is as Mr. Green indicates. People don't know that they can sue for not being treated. Also, if you think about it, if you are poor and you don't have insurance and you are sick, how much energy do you have to sue the facility? Suing really doesn't take care of your problem.

We need the facilities to do what they are supposed to. It is not enough to have this remedy be available to allow people to turn around and sue hospitals if they don't treat properly. It doesn't really solve the problem. Maybe if some people do sue, then hospitals will get the idea that they are not supposed to be dumping patients; they are supposed to be following the law.

Suing is a remedy that most people are not that interested in pursuing.

Mr. Sawyer. It just struck me as shocking that a hospital would feel greater risk from trying to provide service than they would from refusing to try.

Ms. Waxman. I really think that "malpractice liability" is another excuse. We will add that to Mr. Green's long list of excuses. Since there has been attention, particularly in the press in a number of States on this "malpractice crisis," we do hear of a lot of doctors now saying they are not going to treat poor people because they sue more. However, this assumption is absolutely a myth.

As has been said, when you are sick and you are poor, you don't really have the resources or the energy to go out and sue either a physician or a hospital. Nor do you have the desire particularly. Statistics bear out these facts that the poor do not sue more. Yet we are hearing this myth again and again. Doctors tell us, "We won't take poor people because they will sue us and our malpractice insurance is high enough."

It is just another on the long list of excuses, along with "we don't have beds," or whatever else.

Mr. SAWYER. Thank you.

Mr. WEISS. Mr. Konnyu.

Mr. KONNYU. Thank you, Mr. Chairman. Ms. Waxman, about 4 weeks ago, I met for an extended period of time with about six or seven hospital administrators in northern California. We discussed a number of things, and given that there is no national health care, the notion that patients have the "right to choose" through the emergency care provisions was under severe attack by the administrators.

Basically, their argument—one of them that struck me that I remember, is that when patients choose not to go to the public hospital designated by the system to take care of indigents who are not on welfare, and instead go to a private hospital, the severity, that is, the frequency of patients making such independent choices for "emergency" care in nonemergency situations that would in fact bring down the level of services that private hospitals could give their patients. There is a limit to how much of the costs you can transfer to those who have the insurance, and those who have the money if they don't have the insurance, to pay for the regular services.

So, Mr. Green's anecdote becomes a conceptual one as to when do patients have the right to shop for services, just because they are indigent?

Ms. WAXMAN. First of all, in emergency situations, most patients are not shopping. In New York City, you have the situation that Mr. Green described, where you have two facilities within four blocks of each other. But that is a very unusual situation. It exists mainly in high density, metropolitan areas.

When somebody has a bullet in the brain, like the boy I mentioned in Texas, he doesn't shop. He goes to whichever facility is the closest.

Mr. KONNYU. I am focusing specifically on that anecdote as to shopping, because there was a clear decision not to go to the public hospital, which had an appropriate reputation, according to the testimony. Instead, a visit was made to legal services to find out if there was a better place to go and how they could get into that hospital. Legal services then explained how they could get into a better hospital. So that is patient shopping to me.

Ms. WAXMAN. In that regard, I don't know what was in the minds of these particular lawyers, but from what Mr. Green said, they went to their list of facilities which have a Federal obligation to provide a certain amount of uncompensated care. They told him NYU has a Hill-Burton obligation. This obligation lasts for 20 years, and they have allocated *x* amount of dollars that they are supposed to give out in uncompensated care. NYU incurred that obligation when it took money from the Federal Government. I am assuming that that is why that lawyer said—NYU has an obligation that they have not completed for this year.

So, one, the Federal law requires that they take people in an emergency, and this person was deemed to be in an emergency situation, and, two, if he qualifies under these Federal Hill-Burton guidelines, then that facility has to give him uncompensated care by virtue of the Federal obligation that it incurred.

Therefore, he wasn't just picking any facility out of the blue; he was picking one that was on the Hill-Burton list.

Mr. **Konnyu**. What is the impact if private hospitals were required to give on a repeated basis emergency and continuing care until the patient was well enough to be "transferred"? The hospital administrators told me that their ability to deliver services to paying patients would be reduced to the extent that they can't recover costs of uncompensated care by reaching into the pockets of insurance companies or private-pay pockets to pay for that care.

Ms. **Waxman**. Well, two things. One is I am not sympathetic if they have a Hill-Burton obligation that has not been fulfilled as yet, but I am sympathetic to the overall problem that there should be reimbursement for these people, to some degree or other.

The other problem is that sometimes these facilities don't even want to take people who do have reimbursement because it is not large enough.

Mr. **Konnyu**. We have that problem in California because Medi-Cal doesn't pay the kinds of fees that doctors and hospitals get on a private-pay basis. In California there are a significant number of physicians who refuse to treat the indigent because the State forces them to give welfare care by underpaying them.

Ms. **Waxman**. I guess that is the debatable part. I mean, is the amount of money they get sufficient to cover the patients, or is that just another excuse? Is it that they really don't want these "people" here in their facility—I assume there is some of that—and there is also, in some extremes, the legitimate reason that they really are starting to hurt financially.

I think Mr. Stark is trying to address that particular problem, of those hospitals who do indeed take a lot of these people who are uninsured, by getting them some kind of relief, which, I think it is a great idea. But we are never going to really solve the problem unless the coverage is attached to the individual so that hospital administrators can't say, "I can't take them, they are hurting me."

Mr. **Konnyu**. The specific story I remember, there is a husband and wife, a physician-couple, both OB-GYN specialists, in California. As you know, in California we have that $250,000 liability limit when you sue doctors so that their exposure is not that great. Yet each of them—and this was about 2 years ago—were paying $35,000 of liability insurance, which translated, based on the number of babies they delivered, to about $300 per baby per delivery.

I imagine that in other States where there is no liability ceiling it is even higher. So, he was saying, how do I justify, given my high costs, transferring that $300 per delivery when I deliver babies for indigents who don't go to the public hospital for health care? He said that he does some because he is a person of charity and believes in that, but there is a limit to how much he is willing to do because he has a fiscal responsibility to himself and the things that he earns.

So there is a real conflict, not only in that couple but in society as a whole, as to how you create national health care without having national health care. That is what we are trying to do through other means.

Ms. **Waxman**. I appreciate their problem. I think that a lot of people in their situation would say, "I can't take indigent patients because they will sue me," which I said is not borne out by statistics.

Mr. **Konnyu**. They have insurance, so I presume——

Ms. **Waxman**. Well, nobody likes to be sued even if they have insurance. But additionally, you say they say they have a financial obligation to themselves or to the facility. I am not going to judge what I think is "enough" for someone to bring into their family, but my experience is that two physician families are doing OK financially, given the levels of income in the country. If they have to take a few extra poor people, I don't feel that bad about it.

Mr. **Konnyu**. Yes, but do we have the right to take from them their services—the Government forcing it. You see, that is the concept.

Ms. **Waxman**. The forcing, according to this Federal law is only if the patient is in active labor and delivery is imminent. If there is not time to transfer the woman to another facility, then according to this law, they can say—your delivery will not be for some time and you should go to the other facility. However, if delivery is imminent, we are not going to let you deliver in the parking lot which, unfortunately, happens all too frequently. They have a limited obligation.

Mr. **Konnyu**. Let's go back to the original question which was with respect to patient shopping, and this anecdote. The thing that justified it, as I best understood you, was that it was a Hill-Burton facility that had not completed its obligation.

Now what if it was not a Hill-Burton facility and the patient goes on an emergency basis, and insists on treatment because it is an emergency condition even though they have the choice of going to the public hospital?

Ms. **Waxman**. They would have to take the person and care for him until he was stabilized. I think ethics require that.

Mr. **Konnyu**. So that the definition of when a person is stabilized is the critical element.

Ms. **Waxman**. That is how the Federal law reads right now.

Mr. **Konnyu**. Sure, but the question is when is——

Ms. **Waxman**. Right. Ideally, I would like to say that the facility should just keep the patient and give the care needed. We have one physician that works with us that explains the definition of stabilization this way. He says "one doctor's stabilized is another doctor's dump." The transfer hinges on how the doctor applies a legal standard to a medical condition. This flexibility creates a lot of problems. Ideally, every facility should be required to care for people who come to their door, but there is this financial burden which gets us back into the circle of the main problem with our health care system.

Mr. **Konnyu**. Thank you, Mr. Chairman.

Mr. **Weiss**. Thank you, Mr. Konnyu.

Let me take note of and welcome to her first hearing of this subcommittee, our newest Member in Congress, Ms. Nancy Pelosi, from California. Welcome.

Ms. **Pelosi**. Thank you, Mr. Chairman.

Mr. **Weiss**. Thank you for your participation. Do you have any questions at this point?

Ms. **Pelosi**. I am afraid they may have already been asked. I do ask unanimous consent that my opening remarks be included into the record.

Mr. **Weiss**. Without objection, that will be done.

[The prepared statement of Ms. Pelosi follows:]

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COMMITTEE ON GOVERNMENT OPERATIONS
Subcommittee on Human Resources
and Intergovernmental Relations

July 22, 1987

REMARKS

Mr. Chairman, Members of the Subcommittee:

I am pleased to be a part of this important hearing today.

The problem of patient dumping is a growing concern, and especially for those who are in the greatest medical need, and yet without the means to guarantee their medical treatment. It is shocking to me that individuals in our modern age could be denied the right to health based on their economic position.

I am also quite concerned about recent reports of patients being dumped because of the nature of their illness. People who are dumped because they have AIDS,or someone believes that they have AIDS,is simply unacceptable. We need to hear what the Administration is planning to do about this problem.

I look forward to hearing from our witnesses and learning more about the possible solutions to this grave health care crisis.

Thank you, Mr. Chairman.

Ms. **Pelosi**. Excuse me, Mr. Chairman. I must leave. We are having a Banking Committee meeting.

Mr. **Weiss**. I did say at the beginning that Members would be coming in and out because of other obligations.

Again, I want to express my appreciation and that of the entire subcommittee to our first panel of witnesses. You have added an important component to our deliberations on this issue. Thank you. We look forward to your submission, Ms. Waxman.

Ms. **Waxman**. Thank you, very much.

Mr. **Weiss**. The next panel consists of Dr. Arnold Relman, editor, New England Journal of Medicine; Dr. Arthur Kellermann, medical director, Emergency Services, the Regional Medical Center, Memphis, TN; and Dr. David Ansell, attending physician, Division of General Medicine/Primary Care, Cook County Hospital, Chicago, IL.

We have a tradition on this subcommittee of swearing in our witnesses.

[Witnesses sworn.]

Mr. **Weiss**. Let the record indicate that the responses are in the affirmative.

I understand, Dr. Relman, that you have a personal concern and that you have to leave early. What we will do is listen to your testimony and ask a few questions. Then we will excuse you with our gratitude, and go on to hear the testimony of the other panel members.

We have your prepared statement which will be entered into the record in its entirety. You may proceed as you see fit.

STATEMENT OF DR. ARNOLD RELMAN, EDITOR, NEW ENGLAND JOURNAL OF MEDICINE

Dr. **Relman**. Thank you, very much, Mr. Chairman, for the opportunity of expressing my opinions on patient dumping and the equity of access to health care.

I am Arnold S. Relman, M.D., editor of the New England Journal of Medicine, for 10 years, and a professor of medicine at the Harvard Medical School.

I have been a physician for over 40 years and have practiced and taught internal medicine in major academic medical centers for most of my professional life. Before coming to my present post, I served for 9 years as physician-in-chief at the hospital of the University of Pennsylvania in Philadelphia, where I was responsible for not only the in-patient medical services, but for the supervision of large and very busy out-patient and emergency services.

In addition, as a visiting consultant and teacher, I have had an opportunity over the years to become familiar with the emergency medical services of many hospitals all over the country, large and small, public and private. My comments on medical care are therefore based on experience, as well as personal conviction.

Before offering these comments, however, I want to make it very clear that the opinions I express do not necessarily represent the official position of the New England Journal of Medicine, or the Massachusetts Medical Society, which owns the journal. Neither do

I speak for any of the institutions or organizations with which I am affiliated.

In short, the views I offer, even though I have presented many of them in signed editorials in the journal, are strictly my own.

In my view the practice of dumping—that is the unrequested transfer of patients from one hospital to another for purely economic reasons—is one of the saddest and most reprehensible consequences of the growing crisis in the provision of health care for the poor and uninsured.

Medical judgment and patient preference should always prevail over economic and administrative considerations in decisions about the movement of acutely ill or injured patients from one hospital to another. Otherwise, much harm can result.

Urgent illnesses and injuries should be diagnosed and treated promptly. Any doctor knows that. Delays can be dangerous. When a seriously ill or injured emergency patient is transferred to another hospital, there are apt to be risks and discomfort even when the patient is thought to have been "stabilized."

"Stabilization" is a nebulous concept in emergency care, which assumes that appropriate initial treatment can at least relieve symptoms and prevent or delay further deterioration of the patient's condition, thus allowing time for carrying out more definitive diagnoses, or preparing the patient for operation, or arranging for transfer to another facility.

However, the fact is that medical predictions made soon after admission to the emergency room are fraught with uncertainty. Medical judgment under those circumstances is even more difficult when the emergency room medical staff is being pressured by the hospital administrators to transfer the patient as soon as possible. That, I might interject, speaks to the question that Mr. Sawyer asked, what about the ethics of doctors under these circumstances?

Doctors are often under the thumb of the administrator who says "do it, or else."

That is why emergency transfer, unrequested by the patient, can be justified only when there are clear and compelling medical reasons for it, such as the unavailability of the necessary staff and facilities at the transferring hospital.

When medical justification is lacking, unrequested transfers of emergency patients should be prohibited. Period.

Dumping of indigent patients is becoming more common these days, and there is a lot of evidence to that effect, because fewer patients have hospital insurance and because most insurers, Medicare and Medicaid included, are no longer willing to pay hospitals for the extra costs of cross-subsidizing the care of those who are uninsured and those who are unable to pay for themselves.

Such patients were never welcomed at investor-owned, for-profit hospitals, which, even before the recent change in hospital funding, generally discouraged the admission of nonpaying patients and regularly transferred indigent emergency patients as soon as possible.

But, now the voluntary, not-for-profit hospitals are feeling new competitive pressures to reduce costs. Many of these tax exempt, supposedly philanthropic institutions, are also shifting their indigent emergency patients to the nearest public hospital.

This is especially true of the smaller, voluntary, not-for-profit hospitals. The larger, tertiary care teaching hospitals are still trying their best to provide definitive care for all emergency patients, regardless of funding. We heard a story today, which I have no doubt is true and illustrative of many others, which would indicate that even the major tertiary care hospitals are up against the wall and for economic reasons feel constrained to limit the number of indigent, uninsured patients that they take in.

Nevertheless, the economic pressures on all the voluntary hospitals, both large and small, are mounting and there is certainly much less willingness now to subsidize emergency care than there was a decade ago.

Nearly two-thirds of the hospital care of the indigent has traditionally been provided in private, voluntary hospitals. Please remember that. It is not the case that the public hospitals of this country have taken care of most of the indigent, urgently ill patients—not the case at all. It has always been the case that more than half—almost two-thirds—of all the acutely ill patients are taken care of in the voluntary, not-for-profit, nonpublic, private hospitals.

Therefore, the trend in funding which is making it increasingly difficult for the voluntary hospitals to cross-subsidize the care of the indigent is jeopardizing the health of many poor people and putting greater strains on the overloaded and underfunded resources of our public hospitals.

Many public hospitals are now reporting increasing use of their emergency facilities by indigent patients transferred from other hospitals. I am sure you will hear that from Cook County Hospital, and Parkland Hospital, and every other major public hospital in the country. Reports confirm that a substantial fraction of these patients receive substandard care before transfer and some arrive at the receiving hospital in worse condition than if they had been properly attended to before transfer, or if they had not been transferred at all.

Moreover, there is evidence, I am sorry to say, that some unnecessary deaths result from this practice.

On the other hand, it should be clearly recognized that some seriously ill or injured patients who ought to be transferred immediately to a tertiary facility may be unwisely held in the first hospital simply because they are insured.

Some emergency patients can never be "stabilized"—whatever that may mean—until they receive definitive therapy available only in another tertiary, specialized institution.

Economic considerations of any sort should not be allowed to delay the transfer of such patients any more than they should be allowed to precipitate the hasty transfer of patients who don't need to go to another hospital for adequate care.

So it works both ways. In short, medical, not economic considerations, should always determine the unrequested transfer of emergency patients from one hospital to another. Otherwise, grave damage can be done and patients may not receive the standard of care that all Americans are entitled to.

Turning now to the amendment to COBRA that was passed last year, regarding patient transfer, I believe the intent of this legislation is laudable, but I find it flawed in at least one important respect. As I read the law, it allows purely economic or administrative transfers of emergency patients once they have had "stabilizing treatment." Only transfers of unstabilized patients are required to have medical approval and meet the other requirements for so-called appropriate transfer.

As I have already explained, stabilization is hard to define and unreliable. The definition of stabilization given in subsection (E)(4)(b) in the law is deceptively oversimplified and potentially risky to the patient. Regardless of whether appropriate initial treatment intended to stabilize the patient has been given, no emergency patient should be transferred unrequested without a written statement from a competent attending physician, certifying that in his or her judgment the transfer is in the best interest of the patient and explaining why.

I think that the law should have been framed in that way; it would have been simpler. You wouldn't have left it open to discussions about what is stabilization and what is not. The law ought to make clear that only if a competent physician certifies that transfer is in the patient's best interest, should transfer be permitted.

If a doctor insists that it is necessary, even though the patient is economically attractive to the hospital that he first came to, the patient should be transferred—if it is in his best medical interest and he agrees.

Furthermore, the requirements for appropriate transfer as specified in section (C)(2) of the amendments should apply to all emergency transfers, not simply to those of unstable patients. There always ought to be a memo of transfer; the receiving hospital should always know about and agree to the transfer, and so on.

The present version of the COBRA amendment is clearly a step in the right direction, as Ms. Waxman testified, and the modifications I am suggesting would, I believe, make it even more effective and simpler to enforce. She has suggested some other modifications that I agree with.

There are other ways in which Federal legislation could assure fair treatment of indigent emergency patients, and improve the quality of emergency care for all patients, rich or poor. But there is no time to discuss them now, and I am not going to go into that any further, unless you are interested.

I would prefer to use the remainder of my time to consider a much more basic issue that is at the root of the dumping problem. It is the issue Ms. Waxman hinted at; namely, funding of indigent care. We should be under no illusion about what even the most effective kind of antidumping legislation can accomplish without adequate funding.

The elimination of dumping is important, of course, but it leaves the fundamental question untouched; who will pay for the essential medical care of those who have no insurance and cannot afford to pay for themselves? Mr. Konnyu told us that the administrators of these private hospitals quite reasonably and rationally said they would be destroyed economically if they were forced to treat all the emergency patients who choose to come to their emergency rooms.

It is ethically essential that they meet their responsibilities to these patients and the law should require that they do, but we can't ignore the other side of the question which says, who is going to pay? You cannot turn your back on the question. It has been variously estimated that between 30 and 40 million of our citizens are in this category. How should health services for these patients be financed in an increasingly price-sensitive and commercialized system that leaves no room for charity or cross-subsidization?

Competitive markets, even assuming they could operate effectively in medical care, which they certainly cannot, are at best efficient mechanisms for distributing goods and services according to ability to pay, but markets give no attention to those who don't have the money.

Free markets may control prices but they don't do anything to achieve equity, nor may I add do they control total expenditures, particularly when there are third-party payers.

The present administration appears to be relying mainly on the market in health care, however imperfectly it might work. For the delivery of care to those 15 percent of our people who are now priced entirely out of the health care market, the administration seems to be relying on State and local agencies. State and local responses have, to date, been erratic and largely inadequate. The States are simply not prepared, most of them, to assume the financial burden. It is the basic failure of government to provide for necessary health care to the poor that is primarily responsible for the dumping problem.

Legislation against dumping is fine as far as it goes, and I enthusiastically support what the COBRA amendments have tried to do, but it doesn't get to the heart of the matter. Without more support for indigent care, hospitals caring for uninsured emergency patients will be put at a serious economic disadvantage.

The heaviest burden will fall not only on the tax-supported public hospitals, but on the private, not-for-profit teaching hospitals, which constitute the major source of tertiary care in this country and carry the main responsibility for medical education and clinical research.

These hospitals, which receive most of the transfers of indigent emergency patients, cannot be expected to carry this burden without new funding. Although most of the free hospital care given in the past was for emergency and obstetrical services, I would ask you to remember that poor people also need nonemergency medical care, both in and outside the hospital.

They need at least as much care as insured patients do, and probably substantially more.

Mr. Stark, in his opening statement, pointed out that the system has provided in the past for about $7 billion of uncompensated care for the uninsured and the poor. That is grossly inadequate. That only takes care of the tip of the iceberg for urgent emergency cases, short-term acute care and obstetrical care.

Think about it. Hospital care in this country is a roughly $200 billion item; $7 billion is 3 percent. Poor people in this country who can't afford health care are probably at least 10 to 15 percent of the population, if not more. It is obvious that what we have been doing in the past has been grossly inadequate, and it is getting more inadequate because the old system is being torn apart by the loss of the ability to cross-subsidize.

To require that hospitals provide adequate care to all emergency patients, regardless of their ability to pay, is a fine gesture, but it begs the question of who will pay for them, and it also leaves unanswered who will pay for all the other medical services the poor and the uninsured require.

Unless we are prepared to say that we don't care about the health care needs of 30 or 40 million of our citizens, we must address these questions now. It is morally and politically unacceptable for the Federal Government to turn its back on this problem, while doing all it can to reduce the Federal commitment and turn health care over to private markets.

In my view, only a few States and localities can be expected to have the resources and the social commitment to provide adequate care for their poor. It seems clear to me that this is a problem calling for a national solution. That solution will undoubtedly require the appropriation of new tax funds.

Those who advocate competitive markets in health care and focus on price control are not being honest with the public if they do not also explain that private health markets are for the insured and the well-to-do. The uninsured, the underinsured and the poor—and their numbers are growing rapidly—will need public help.

Taxes will have to replace the charity and the cross-subsidization which formerly dealt with the problem, although as I have pointed out, inadequately. As I see it, the question is not whether we need more public funding of health care, but how, and in what type of system this funding should be applied.

The Congress and the administration cannot avoid facing this issue because the public, when it becomes aware of the problem, will insist that Government meet its obligation to provide necessary medical care to all who need but cannot afford it.

The task will be to see that this care is provided in a way that preserves quality and is not prohibitively expensive.

In my opinion, those who are adequately insured through their place of employment should continue to be insured in that way. And employers not now providing health care insurance to their employees should be required to do so. People who are self-employed or unemployed, but whose incomes are adequate to pay for their own insurance should assume that responsibility.

Tax funds, in my view, should be used to buy health care for those who cannot do it for themselves.

Federally subsidized health insurance for the poor should provide for delivery by the private sector, but the quality as well as the cost of the care should be carefully regulated to ensure that poor people do not get inferior care and that they have access to the main stream, not to separate and therefore inevitably unequal facilities.

To avoid the errors of Medicare, and they were enormous in my opinion, Federally subsidized insurance in the future will need to rely on better methods of payment, and more regulation. Those who claim that an unregulated health care market will achieve the goals of cost control, equity and preservation of quality either don't understand what medical care is all about, or are not being forthright with the public.

We will clearly need more regulation in the future, not less. What we must insist on, however, is that the regulation be sensible and fair and that it reflect the views and legitimate needs of patients and providers.

In closing, I would simply make a few observations on what needs to be done by physicians to help achieve better access at an affordable cost. The medical profession will need to participate in cost and quality control to a far greater extent than it has ever done before. To make this possible, physicians' organizations will need to support some revision of current fee schedules and encourage more salaried and group practice arrangements.

We will also need much more information about technology assessment to help physicians make better, more effective decisions for their patients, and we will have to deal with the growing imbalance between the numbers of specialists and generalists. We have too many specialists and too few doctors delivering primary care, which contributes to the impossible cost burden that we have been staggering under.

All this will require careful planning, field trials, demonstration projects, and much cooperation among government, doctors, and institutional providers. It is a formidable, but by no means impossible, agenda. We ought to waste no more time in getting on with the task.

Thank you, very much.

[The prepared statement of Dr. Relman follows:]

Testimony of Dr. Arnold S. Relman before the U.S. House of Representatives Human Resources and Intergovernmental Relations Subcommittee of the Committee on Government Operations, July 22, 1987.

Subject: Equity of Access. Patient Dumping

Mr. Chairman: Thank you for the opportunity of expressing my opinions on patient dumping and equity of access.

I am Arnold S. Relman, M.D., for the past ten years Editor of *The New England Journal of Medicine*, and Professor of Medicine at the Harvard Medical School. I have been a physician for over forty years and have practiced and taught Internal Medicine in major academic medical centers for most of my professional life. Before coming to my present post, I served for nine years as Physician-in-Chief at the Hospital of the University of Pennsylvania in Philadelphia, where I was responsible not only for the inpatient medical services but for the supervision of large and very busy outpatient and emergency services. In addition, as a visiting consultant and teacher I have had an opportunity over the years to become familiar with the emergency medical services of many hospitals, large and small, public and private. My comments on medical care are therefore based on experience as well as personal conviction.

Before offering these comments, however, I want to make it very clear that the opinions I express do not necessarily represent the official position of *The New England Journal of Medicine* or the Massachusetts Medical Society, which owns the *Journal*. Neither do I speak for any of the institutions or organizations with which I am affiliated. In short, the views I offer, even though I have presented many of them in signed editorials in the *Journal*, are strictly my own.

In my view, the practice of "dumping," i.e., the unrequested transfer of patients from one hospital to another for purely economic reasons, is one of the saddest and most reprehensible consequences of the growing crisis in the provision of health care for the poor and the uninsured.

Medical judgment and patient preferences should always prevail over economic and administrative considerations in decisions about the movement of acutely ill or injured patients from one hospital to another; otherwise much harm can result. Urgent illnesses and injuries should be diagnosed and treated promptly. Delays can be dangerous. When a seriously ill or injured emergency patient is transferred to another hospital, there are apt to be risks and discomfort, even when the patient is thought to have been "stabilized". "Stabilization" is a rather nebulous concept in emergency care, which assumes that appropriate initial treatment can at least relieve symptoms and prevent or delay further deterioration of the patient's condition, thus allowing time for carrying out more definite diagnosis, or preparing the patient for operation, or arranging for transfer to another facility. However, the fact is that medical predictions made soon after admission to the emergency room are fraught with uncertainty. Medical judgment is even more difficult when the emergency room medical staff is being pressured by the hospital administrators to transfer the patient as soon as possible.

That is why emergency transfer unrequested by the patient can be justified only when there are clear and compelling medical reasons for it, such as the unavailability of the necessary staff and facilities at the transferring hospital. When medical justification is lacking, unrequested transfers of emergency patients should be prohibited.

Dumping of indigent patients is becoming more common, these days because fewer patients have hospital insurance and because most insurers -- Medicare and Medicaid included -- are no longer willing to pay hospitals for the extra cost of cross-subsidizing the care of those who are uninsured and unable to pay for themselves. Such patients were never welcome at investor-owned for-profit hospitals which, even before the recent change in hospital funding, generally discouraged the admission of non-paying patients and regular transferred indigent emergency patients as soon as possible. But now that private not-for-profit hospitals are feeling new competitive pressures to reduce costs, many of these tax-exempt, supposedly philanthropic institutions are also shifting their indigent emergency patients to the nearest public hospital. This is especially true of the smaller voluntary hospitals. The larger, tertiary care teaching hospitals are still trying their best to provide definitive care for all emergency patients, regardless of funding. Nevertheless, the economic pressures on all the voluntary hospitals -- both large and small -- are mounting,and there is certainly much less willingness now to subsidize emergency care than there was a decade ago.

Since nearly two thirds of the hospital care of the indigent has traditionally been provided in private voluntary hospitals, this trend is jeopardizing the health of many more poor people and putting greater strains on the overloaded and underfunded resources of our public hospitals. Many public hospitals are now reporting increasing use of their emergency facilities by indigent patients transferred from other hospitals. Reports confirm that a substantial fraction of these patients receive substandard care before transfer and some arrive at the receiving hospital in worse condition than if they had been properly attended to before transfer or if they had not been transferred at all. Moreover, there is evidence that some unnecessary deaths result from this practice.

On the other hand, it should be clearly recognized that some seriously ill or injured patients who ought to be transferred immediately to a tertiary care facility may be unwisely held in the first hospital simply because they are insured. Some emergency patients can never be "stabilized" until they receive definitive therapy that is available only in another institution. Economic considerations should not be allowed to delay the transfer of such patients any more than they should be allowed to precipitate the hasty transfer of patients who don't need to go to another hospital for adequate care.

In short medical, not economic, considerations should determine the unrequested transfer of emergency patients from one hospital to another. Otherwise, grave damage can be done and patients may not receive the standard of care that all Americans are entitled to.

Turning now to the amendment to COBRA that was passed last year regarding patient transfer: I believe the intent of this legislation is laudable, but I find it flawed in at least one important respect. As I read the law, it allows purely economic or administrative transfers of emergency patients once they have had "stabilizing" treatment. Only transfers of unstabilized patients are required to have medical approval and to meet the other requirements for a so-called "appropriate" transfer. As I have already explained, "stabilization" is hard to define and unreliable. The definition given in subsection (e) (4) (B) is deceptively oversimplified and potentially risky to the patient. Regardless of whether appropriate initial treatment intended to stabilize the patient has been given, no emergency patient should be transferred, unrequested, without a written statement from an attending physician certifying that in his or her judgment the transfer is in the best interests of the patient -- and explaining why. Furthermore, the requirements for "appropriate" transfer, as specified in subsection (c) (2) of the amendment should apply to all emergency transfers, not simply to those of unstable patients.

The present version of the COBRA amendment is clearly a step in the right direction, however, and the modifications I am suggesting would, I believe, make it even more effective and simpler to enforce.

However, we should be under no illusions about what even the most effective kind of anti-dumping legislation can accomplish. The elimination of dumping is important, but it leaves the fundamental question untouched: Who will pay for the essential medical care of those who have no insurance and cannot afford to pay for themselves? It has been variously estimated that between 30 and 40 million of our citizens are in this category. How should health services for these people be financed in an increasingly price-sensitive and commercialized system that leaves no room for charity or cross-subsidization? Competitive markets, even assuming they could operate effectively in medical care -- which they certainly cannot -- are at best efficient mechanisms for distributing goods and services according to ability to pay. But markets pay no attention to those who don't have the money. Free markets may control prices, but they don't do anything to achieve equity.

The Reagan Administration appears to be relying mainly on the market in health care -- however imperfectly it may work. For the delivery of care to those 15% of our people who are now priced entirely out of the health care market, the administration seems to be relying on state or local agencies rather than the federal government. But state and local responses have to date been erratic and largely inadequate.

It is the basic failure of government to provide for necessary health care to the poor that is primarily responsible for the dumping problem. Legislation against dumping is fine as far as it goes but it doesn't get to the heart of the matter. Without more support for indigent care, hospitals caring for uninsured emergency patients will be put at a serious economic disadvantage. The heaviest burden will fall not only on the tax-supported public hospitals, but on the private not-for-profit teaching hospitals which constitute the major source of tertiary care in this country and carry the main responsibility for medical education and clinical research. These hospitals, which receive most of the transfers of indigent emergency patients, cannot be expected to carry this burden without new funding.

Although most of the free hospital care given in the past was for emergency and obstetrical services, I ask you to remember that poor people also need non-emergency medical care, both in and outside the hospital; they need at least as much care as insured patients do -- probably substantially more.

To require that hospitals provide adequate care to all emergency patients, regardless of their ability to pay, is a fine gesture -- but it begs the question of who will pay for them. And it also leaves unanswered who will pay for all the other medical services the poor and uninsured require.

Unless we are prepared to say that we don't care about the health needs of 30 or 40 millions of our citizens, we must address these questions now. It is simply morally and politically unacceptable for the federal government to turn its back on this problem, while doing all it can to reduce the federal commitment and turn health care over to private markets.

In my view only a few states and localities can be expected to have the resources and the social commitment to provide adequate care for their poor. It seems clear to me that this is a problem calling for a national solution. That solution will undoubtedly require the appropriation of tax funds. Those who advocate competitive markets in health care and focus on price control are not being honest with the public if they do not also explain that private health markets are for the insured and the well-to-do. The uninsured, the underinsured and the poor (their numbers are rapidly growing) will need public help. Taxes will have to replace the charity and cross-subsidization which formerly dealt with the problem, however inadequately.

As I see it, the question is not whether we need more public funding of health care but how and in what type of system this funding should be applied. Congress and the Administration cannot avoid facing this issue, because the public will insist that government meet its obligation to provide necessary medical care to all who need but cannot afford it.

The task will be to see that this care is provided in a way that preserves quality and is not prohibitively expensive. Those who are adequately insured through their place of employment should continue to be insured in that manner. Those who are self-employed or unemployed but whose incomes are adequate to pay for their own insurance should be expected to do so. Federally subsidized health insurance for the poor should provide for delivery by the private sector, but the quality as well as the cost of the care should be carefully regulated, to insure that poor people do not get inferior care.

To avoid the economic errors of Medicare federally subsidized insurance in the future we will need to rely on better methods of payment and more regulation. Those who claim that an unregulated health care market will achieve the goals of cost-control, equity of access and preservation of quality either do not understand what medical care is all about or are not being forthright with the public. We will clearly need more regulation in the future, not less. What we must insist on, however, is that the regulation be sensible and fair and that it reflect the views and legitimate needs of patients and providers.

In particular, the medical profession will need to participate in cost and quality control to a far greater extent than it has ever done before. My guess is that to make this possible, physicians' organizations will need to support some revision of current fee schedules and encourage more salaried and group practice arrangements. We will also need much more information about technology assessment to help physicians make better, more effective decisions for their patients; and we will have to deal with the growing imbalance between the numbers of specialists and generalists. We have too many specialists and too few doctors delivering primary care.

All this will require careful planning, demonstration projects, and much cooperation between government, doctors, and institutional providers. It is a formidable, but by no means impossible, agenda. We ought to waste no more time in getting started with the task.

Mr. **Weiss**. Thank you, very much, Dr. Relman. Because your statement has been so thorough, and because of your time concerns, I am going to limit my questions and then ask the other members if they have questions before we excuse you.

I assume that the readers of your journal are predominantly physicians, right?

Dr. **Relman**. That is correct.

Mr. **Weiss**. I assume that you have been writing signed editorials which, in essence, reflect the same viewpoint that you have presented to us today.

What has been the reaction of your physician/subscribers to the proposals, or thrust of your thinking?

Dr. **Relman**. It is hard to say, Mr. Weiss. Doctors are not inclined to take pen in hand and write letters to the editor. Those letters that we get, I would say, are mixed in response. In general, it has been my experience over the years that those who object to what you have to say are more likely to write than those who agree.

Nevertheless, it is my impression from traveling around the country and talking to groups of physicians, that the majority of doctors agree with what I am saying.

Mr. **Weiss**. That is, I would assume, a significant change. I think back to the days when we were fighting over the adoption of Medicare legislation, when almost the entire medical profession—not totally, but almost all—seemed to be in opposition to the thrust of that program.

Things have changed now?

Dr. **Relman**. Yes. It is a different world now. The economic climate has changed. We see the consequences of many of the policies and the attitudes that we lived by a generation ago.

Second, I would point out to you that the medical profession is changing. The American population is graying, but the medical profession is greening. We are getting younger. Also, we are getting more females, I am glad to say. Young, increasingly female physicians, have a different social outlook.

Mr. **Weiss**. Thank you. Mr. Sawyer.

Mr. **Sawyer**. Thank you, Mr. Chairman. Doctor, the proposal that you have outlined on the third page of your testimony, about written explanations accompanying any transfer, explains the medical reasons. What should we reply to the inevitable argument that we will receive from some in your profession, probably even others among administrators of hospitals, that we will be creating unnecessary paperwork and in fact perhaps standing in the way of timely and appropriate medical treatment—another bureaucratic burden—you have heard all the arguments. I won't repeat them here.

How do we reply to what I suspect is really more concern, perhaps even fear, of establishing a paper trail that is unnecessary and imposing?

Dr. **Relman**. Mr. Sawyer, the answer to your question is very simple. The answer is that what I am suggesting is what every director of a medical service demands of members of his or her staff. It is considered good medical practice. It is expected that when an acutely ill patient is transferred, the physician who is making the decision to transfer and the physician who agrees to accept state clearly what the medical reasons are.

As a director of a medical service, when I received sick patients transferred from another facility without that kind of statement explaining why it was medically important, I was very unhappy. I suspected, usually correctly, that there was inadequate medical attention being paid to the problem.

That is no more paperwork than good medical care would require. Any good medical record would have that information.

Mr. Sawyer. Any good, responsible medical record.

Dr. Relman. Correct.

Mr. Sawyer. Thank you.

Mr. Weiss. Thank you, Mr. Sawyer. Ms. Pelosi.

Ms. Pelosi. Thank you, Mr. Chairman.

Dr. Relman, I was very pleased to hear some of your remarks this morning. Thank you.

I am very concerned about AIDS, and I wondered if you saw in this issue of dumping any special precautions that may be necessary, or any special problems that are likely to arise that we should be prepared for in relationship to AIDS.

Dr. Relman. AIDS is a terrible national and international problem. It is having an enormous impact on the health delivery system in certain areas of the country. I am sorry to say that some members of my profession seem to be expressing the view that they don't want to take care of patients with AIDS, or that they must know what the blood test is before they undertake to provide medical treatment.

I think that is unfortunate. I am certain it represents a minority view, and I don't think it will, or should, have any impact on the way patients are treated in emergency rooms.

Being a doctor is a privilege and also a responsibility. Certain risks come with the territory. It is AIDS now, but when I was a young doctor, it used to be tuberculosis that you worried about getting. But if you are an ethical physician, you take care of the patients who come to you whether or not you are at risk and you take your chances.

Ms. Pelosi. So you don't see the dumping of patients who are suspected of having AIDS as a current problem?

Dr. Relman. I am not aware of that problem. It may happen in the future, but what I am saying is that it runs directly contrary to the ethical consensus of the profession, and such behavior would be condemned by the great majority of American physicians.

Ms. Pelosi. Thank you, Dr. Relman.

Mr. Weiss. Thank you, very much, Dr. Relman. I know that you have urgent reasons for leaving us as quickly as possible. We very much appreciate your joining us this morning and giving us the benefit of your knowledge.

Dr. Kellermann, we will continue with you. Again, your entire statement will be entered into the record, and if you can summarize or present it in a highlighted fashion, it would be appropriate to do that.

STATEMENT OF DR. ARTHUR L. KELLERMANN, MEDICAL DIRECTOR, EMERGENCY SERVICES, REGIONAL MEDICAL CENTER, MEMPHIS, TN

Dr. KELLERMANN. Thank you, Mr. Chairman, and members of the committee for inviting me today. I am chief of the Division of Emergency Medicine at the University of Tennessee, Memphis, and the director of the emergency department at the Regional Medical Center at Memphis ("the Med"), the major provider of health care for the poor and uninsured citizens of Memphis, TN, Shelby County, and the surrounding Midsouth area.

I will add a qualifier, as Dr. Relman did a few minutes earlier, and state that the opinions that I am about to present are mine only and do not necessarily represent those of the University of Tennessee, Memphis.

What I would like to do, Mr. Chairman, with your kind permission would be to preface my remarks with a short tape recording of a telephone conversation, and if it would please the chairman, I can provide you with a brief transcript that will allow you to follow the dialog. I think it will help set the stage for what we are talking about this morning.

Mr. WEISS. Fine.

[The information referred to follows:]

REGIONAL MEDICAL CENTER AT MEMPHIS
EMERGENCY DEPARTMENT

Transcript Dated 9/14/86

(Comments and explanations are indicated by parentheses)

MED PHYSICIAN:

Hello, this is Dr. Souther

TRANSFERRING PHYSICIAN:

Dr. Souther?

MED PHYSICIAN:

Yes

TRANSFERRING PHYSICIAN:

Hi, this is . . . (omitted)

MED PHYSICIAN:

This conversation is being recorded it is uh, 0505 on 9/14/86, please go ahead.

TRANSFERRING PHYSICIAN:

Okay, I've got a gentleman 36 years old thats got an acute inferior infarction, no prior history of this or chest pain, has a past history of kidney stones on no medication. He was having difficulty starting his lawn mower when he developed chest pain and diaphoresis (sweating). He came in here complaining of chest pain and diaphoretic (sweating), vital signs stable and an EKG shows an acute infarction (a heart attack), and I was wondering if maybe the city would (accept this patient) . . . This hospital doesn't do cardiac catherization, which this guy probably needs*.

MED PHYSICIAN:

Um, is um, that, the only reason for the transfer?

TRANSFERRING PHYSICIAN:

Uh, of course he is indigent too, although he is gainfully employed.

MED PHYSICIAN:

Okay, is he a Shelby County resident?

TRANSFERRING PHYSICIAN:

He is.

MED PHYSICIAN:

And uh, is he currently pain free?

*Editorial note: cardiac catherization is a diagnostic procedure that is normally delayed for several days or weeks until a patient is stable - following a heart attack. It if rarely indicated during the event itself.

TRANSFERRING PHYSICIAN:

Uh, yea he got pretty good relief with one nitroglycerine, I went, however after that I went ahead and gave him 4 more uh, gave him 4mg of Morphine IV (intravenously). He's had 10,000 units of heparin IV and he's got uh, 6 liters of O2 (oxygen) and D5W (IV fluid) to keep open (a slow rate of infusion).

MED PHYSICIAN:

Uh, hold on just a moment.

TRANSFERRING PHYSICIAN:

Okay

MED PHYSICIAN:

Do you have any uh indigent care beds there at your hospital?

TRANSFERRING PHYSICIAN:

We do not.

MED PHYSICIAN:

Do you have any beds at all at your hospital?

TRANSFERRING PHYSICIAN:

Yes.

MED PHYSICIAN:

Okay

TRANSFERRING PHYSICIAN:

See most of these, most of the acute infarctions from here we transfer out because of cardiac cath.

MED PHYSICIAN:

Okay, uh, we do have unit beds available so yes we can accept the uh transfer.

TRANSFERRING PHYSICIAN:

Okay

MED PHYSICIAN:

Um, is has he had any uh ventricular ectopy . . . (abnormal heart beats that can warn of a possible cardiac arrest)

TRANSFERRING PHYSICIAN:

He has not. I'm gonna give him 75 of lidocaine (a potent intravenous medication to stablize the heart beat) and put him on a drip just for precautionary measures until you know, until he gets down there. He, as I said, he's had 10,000 of heparin, 4mg of morphine, 1 nitro and uh the uh lidocaine which I'm gonna give prior to transfer. He will be accompanied by a nurse.

MED PHYSICIAN:

Okay, good.

TRANSFERRING PHYSICIAN:

Hey, I sure appreciate it.

MED PHYSICIAN:

And could you give me his name please?

TRANSFERRING PHYSICIAN:

Yea, Jimmy . . .

MED PHYSICIAN:

Okay, we will be expecting him.

TRANSFERRING PHYSICIAN:

I will call you back Dr. Souther if there is any change in his status for whatever reason.

MED PHYSICIAN:

Okay, good thank you.

TRANSFERRING PHYSICIAN:

Okay, thank you.

Follow Up:

This patient arrived at 5:51PM after receiving an additional 2mg (milligrams) of Morphine intravenously. He arrived in distress with severe ongoing chest pain and received an additional 6mg of intravenous Morphine as well as intravenous streptokinase, a potent medication used to dissolve clots in coronary arteries. He was then admitted to the medical intensive care unit.

Dr. **Kellermann**. A few followup comments are in order. This patient arrived 45 minutes later at the Regional Medical Center at Memphis emergency department.

After receiving an additional dose of intravenous morphine prior to transfer, on arrival he was experiencing severe substernal chest pain. He received an additional three doses of intravenous morphine in our emergency department, as well as streptokinase, a potent medication used to dissolve clots in coronary arteries. He was then admitted to our medical intensive care unit.

Lab tests subsequently revealed that he had, in fact, sustained a myocardial infarction, or what most of us refer to as a heart attack. He was having that heart attack during his transfer from the other hospital.

I would hasten to add that the facility in question was fully capable of providing medical care to this gentleman. The argument advanced by the transferring physician was that this patient needed a procedure called a cardiac cath. That procedure is normally done several days and sometimes weeks after an acute heart attack, when a patient is stable.

This individual did subsequently undergo cardiac catheterization in our hospital, 9 days following his transfer.

Now, this case was only one of an estimated 1,100 patients transferred to the med emergency department over the past 12 months for primarily economic reasons. This estimate of 1,100 is almost certainly very conservative because I don't include in that count patients that are transferred to one of the med's four regional centers of excellence: Our trauma center, our burn unit, our neonatal intensive unit, or our high-risk obstetric service.

In fact, two patients are transferred to one of these four units for every one that is sent to our emergency department.

Now, I know from experience and from talking to my colleagues, that probably half of the high-risk obstetric emergency referrals are in fact poor women with uncomplicated pregnancies, and probably 15 to 20 percent of the "trauma center referrals" are relatively minor or easily manageable injuries, but are sent because the patient is unable to pay.

But to be fair and not to go on a case-by-case basis and try to tease that out, we simply assumed for purposes of those numbers that I quoted you, that all of those patients in fact represented legitimate tertiary care referrals.

Now that is a point that I think we really need to understand because it is oftentimes blurred or confused by critics of antidumping regulations. We are not talking about the referral of unstable patients who desperately need special services unavailable at the hospital that they first go into.

We are talking about the transfer of patients who are sick, who are ill, who are seriously injured and who could very, very well obtain necessary services at the hospital where they are first seen but instead are transferred for economic reasons.

Mr. **Weiss**. Because there is a vote on the floor of the house, we will take a recess for approximately 10 minutes.

Dr. **Kellermann**. Thank you.

[Brief recess.]

Mr. **Weiss**. The subcommittee will resume its session. If the witnesses will resume their seats at the witness table—before we start up again, let me just indicate that after having checked with the schedule on the floor, as well as the timeframe that we will be operating in, at the conclusion of this panel of witnesses, we will recess for an hour for lunch and then resume to complete the hearings.

Dr. Kellermann, we had interrupted your testimony with the bells.

Dr. **Kellermann**. That is all right; thank you, Mr. Chairman.

As I was saying immediately before the break, our estimate of 1,100 patients over the past 12 months is a conservative one because we did not include patients sent to one of the four centers of excellence that are operated by the Regional Medical Center at Memphis. These are clinical units that offer a level of service and expertise unavailable at other hospitals in the Midsouth area.

The situation with my emergency department is quite different. Memphis has several large, very well financed, very powerful, private hospitals, all of whom offer identical emergency services to those available at our facility.

In our case, the vast majority of patients transferred to the Med emergency department are therefore in fact sent because the hospital, while capable of providing needed medical care, has chosen not to for financial or for economic reasons.

Before you, on the table in front of me, are patient ID wristbands that are used in every hospital in this country to help identify a patient. These are taken from the wrists of patients transferred to the emergency department at the Med over about a 4-month period.

I have counted out 271 of those wrist bands to give you and the rest of the members of the committee some idea of what 271 means in this case. I know all of you are used to dealing with much larger numbers—oftentimes millions and billions, and 271 may not seem like many, but it is important to remember that this is not an abstract figure but in fact represents 271 human beings.

As others have emphasized before me and as I want to emphasize, this is very clearly a national problem. These bands represent the total number of cases transferred to the Med for primarily economic reasons, over a 92-day period. This is only a single, publicly supported hospital.

If we included the patients documented in the study by Dr. Ansell, my colleague at this table, we would need two more tables like this one. If we included the patients dumped at Highland General Hospital in Oakland, CA, documented in the American Journal of Public Health, we would need an additional two tables.

Add the cases reported by the 26-member institutions of the much larger National Association of Public Hospitals, and we would need four additional tables. Those cases were documented in those 26 hospitals in only a 2-week period.

If we included the annual total of patients transferred to Parkland General Hospital in Dallas, the vast majority of which are sent for economic reasons, we would need six more tables. So we are talking about a major problem, both in distribution and in terms of magnitude.

Dr. Relman and others have stated, more eloquently than I can, the dynamics that are leading to patient dumping. I believe that any city or metropolitan area that has one or more private hospitals locked in intense competition, and one or more hospitals that have identified themselves as willing to provide necessary medical care to all, regardless of their ability to pay, will have dumping.

As long as you have a hospital under financial constraints or pressures to reduce bad business practices—and believe me, from an entrepreneur's perspective, taking care of charity patients is bad business—and if you have another hospital that says, "We have a mission to care for these people," they will be sent from the first hospital to the second hospital.

The bulk of my data, the quantitative data, has been submitted to the committee in written form. In the interests of time, I will not walk through all of it now. I do believe that our data and the research of Dr. Ansell and others has amply documented that dumping is common, that patients are frequently sent to receiving hospitals without any authorization and oftentimes without any advance telephone contact; that many are sent in unstable or even critical condition from hospitals fully capable of providing necessary emergency services; and that most cases of dumping, the great majority, occur without the patient being aware of the real nature or reason for their transfer. Most occur without the patient's consent.

Now, I have also included in my written report eight case histories, all of which are true, that have occurred in the past 9 months, since the implementation of the provisions of COBRA. All of them involve serious cases of patient dumping, all of them involve critical patients.

Three of the patients cited in those eight case histories died. Two died in our hospital, actually one died immediately prior to transfer.

We have addressed within that written report some additional suggestions for changing, amending or helping to craft regulations that will plug some of the loopholes that I think these cases illustrate.

Given the seriousness of this situation, my colleagues and I in Memphis and in the State of Tennessee have not been idle. We have been trying, through a series of hearings in Nashville, through press reports in Memphis, and through other public commentary, to raise this issue and increase the public's awareness of the problem of dumping.

When there has been media attention to dumping, in my hospital at least, we have seen the rate of transfer of indigent patients dramatically decrease for about 10 or 12 days. But when the floodlight of public scrutiny is snapped off and goes on to another issue, we are very rapidly back to what can only be called "business as usual."

In Tennessee and elsewhere, local and State efforts to regulate or stop patient dumping have been largely ineffective. They have often been frustrated by the power of the hospital lobby, or efforts have simply been ignored.

For example, in Tennessee, lobbyists for the Tennessee Hospital Association successfully amended draft legislation to regulate dumping just before it was passed in the Tennessee General Assembly. Specifically, they were able to amend, wherever it appeared in the bill, the word "patient" to read "in-patient," a rather clever maneuver when you consider that 95 percent of patient dumping, in my estimation, occurs in the emergency department. In effect, they gutted the bill before it ever got out of the general assembly.

I have a memorandum that was circulated to executives of the hospital association, proudly attesting to how they had successfully limited the damage that otherwise would have occurred from this bill.

In subsequent hearings before the State Board for Licensing Health Care Facilities—incidentally, the same body that reviewed the Terry Takewell complaint—we have submitted our documentation of patient transfers, and they have heard testimony from a variety of consumer groups and grass roots organizations from around the State.

Unfortunately, the board has been remarkably ambivalent about taking concrete steps to draft regulations to deal with dumping. After three hearings and assurances from the State attorney general's office that they could go beyond the restrictive language of the State law, the board has reluctantly agreed in principle that they will include emergency department patients in regulations.

However, those regulations have yet to be drafted, and under further pressure from the State hospital association, the board has decided that we need four more hearings in the major cities of Tennessee to allow private hospitals time to review the draft regulations and respond to their implications for finances and operations.

A year and a half after the Tennessee law was passed, we have yet to have any kind of effective regulations on our books. That states, I think, more clearly than anything else the power that we are likely to encounter on a State level when attempting to deal with patient dumping.

Now, COBRA, as it was passed or implemented in August of last year, could be effective. It is an important beginning step. However, its effect has also been very limited. I have not personally observed it to have any effect whatsoever on the nature, the number or the types of patients transferred to the Med for primarily economic reasons. I again refer to the eight case histories in our written report.

I believe this has been due, in part, to the fact that physicians and hospitals are really unfamiliar with the specific requirements of COBRA.

I think that public hospitals, and I would add to that, regrettably, my own, are reluctant to inform the health care financing administration of potential violations of COBRA. We all have to work with each other in these cities, and many times administrators feel that it is better to try to work "through channels" or through collegial relationships than to "bring in the Feds." So there has been a real reluctance by hospitals to report cases.

Most patients, as I have already commented, are unaware that they have been "dumped." If they are aware, they simply don't have the energy or the courage to tackle a major health care institution.

HCFA has failed to develop a comprehensive monitoring or reporting system to detect cases of patient dumping. Basically, they are more than content to sit back and wait for the phone to ring, and I have already commented that that is an unlikely event at best.

Finally, I believe HCFA has failed to review potential violations in a manner which can be shielded from local or State level political considerations, a comment we may want to discuss later in the question and answer period.

We have several recommendations that we have submitted in written form to address draft regulations to implement the effects of COBRA. I won't go through all of them, but I do consider three to be particularly important. Some will echo the comments of earlier speakers.

I believe we clearly have to address what in the world we mean by "stabilization," otherwise, it is a loophole big enough to drive a tank through. Whether we use a national standard of care, similar to malpractice litigation, whether we use Dr. Relman's rule, that in any case of transfer, the medical benefits to the patient should outweigh the risks—we simply have to get a handle on that issue.

The second major point, and I would echo Dr. Relman's opinion very strongly, is that, I believe a requirement for written certification is essential. We must insist on documentation of the reason for transfer, the patient's condition at the time of transfer, and the risks and benefits associated with transfer. Those should be specified in every case prior to transfer, so that if Dr. Ansell asks to transfer a patient to my hospital, and he is 10 miles away, down the street, and he says, yes, this patient is stable—and if the patient then arrives in life-threatening condition—I want a piece of paper with Dr. Ansell's name on it saying "I certify that this patient is stable for transfer; there are no risks associated with transfer and the benefits are * * *" whatever. Then I can protest the transfer. While this will be a single piece of paper, it will be a very important one, and records should be kept in every case of transfer in both sending and receiving hospitals. I would suggest that HCFA or perhaps the Joint Commission for Accreditation of Hospitals, or some other delegated body should periodically review these records, starting with publicly supported hospitals, and perhaps look at every fourth or fifth case. HCFA should not wait for a complaint, but should audit hospitals periodically to see if transfers are being accomplished in a reasonable manner.

Finally, I would strongly urge this committee to consider recommending that we include a provision for patient consent. It is a fundamental American right that a patient should not be subjected to a potentially hazardous procedure, whether that be an operation or interhospital transfer, without informed consent. I think informed consent should be required in the case of any interhospital transfer.

If the patient is incompetent, or a minor, consent should be obtained from a responsible legal guardian. If no guardian is available, the patient is unconscious or in extremely critical condition, then the principle of implied consent can be invoked, the same way we do now when we rush a critically ill or injured patient to emergency surgery.

I do not see a requirement for patient consent obstructing or hindering the legitimate transfer of emergency patients for tertiary care. It will simply safeguard the patients that we are discussing here today.

As Dr. Relman has said, basically, dumping is simply a symptom of a much more serious national illness; that illness is inadequate health care financing in this country for poor and uninsured Americans.

It is estimated there are over 35 million Americans without adequate health insurance. While many of them are like the gentleman in the tape recording you heard, and are "gainfully employed," they are still subjected to the risks and hazards of transfer in a totally inappropriate manner.

I think that antidumping regulations are therefore a critically needed bandaid. They are a bandaid for sure, but a very, very necessary bandaid to deal with an extremely serious and visible problem.

Many hospital administrators in this country, and many private physicians, have regretted that antidumping regulations are being passed, discussed or implemented. Those of us who work in public hospitals regret that they are necessary.

Thank you for your time.

[The prepared statement of Dr. Kellermann follows. See app. pp. 385–432 for additional information.]

EMERGENCY DEPARTMENT PATIENT "DUMPING" IN MEMPHIS, TENNESSEE:

AN ANALYSIS OF INTERHOSPITAL TRANSFERS TO THE REGIONAL MEDICAL CENTER AT MEMPHIS

Submitted to the
Human Resources and Intergovernmental Relations Subcommittee
of the
Committee on Government Operations
Congress of the United States
House of Representatives

July 22, 1987

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The views expressed are those of the authors and do not necessarily reflect those of the University of Tennessee, Memphis.

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SUMMARY STATEMENTS

This report is based on data collected in the Emergency Department (ED) of the Regional Medical Center at Memphis, the major provider of adult indigent health care for Memphis and Shelby County, Tennessee. Conclusions are based primarily on an intensive audit of interhospital transfers to the Med ED conducted between June 1 and August 31, 1986. Preliminary analysis of interim data from a second audit currently in progress is also presented. Based on these studies we make the following observations:

1) **Private hospitals and free standing emergency centers frequently transfer patients to the Med ED for primarily economic reasons.** In over 80 percent of 161 telephone requests for transfer to the Med received during the summer of 1986, "no money" or "no insurance" was identified by the requesting physician as the primary reason for transfer.

2) **Private hospital physicians frequently transfer patients without any telephone request for authorization.** In almost two thirds of cases, patients arrive at the Med without advance telephone authorization.

3) **Private hospitals often try to send patients in critical or unstable condition.** During the 1986 study period, a total of 66 telephone requests for transfer were refused. Over half of these refusals involved patients who would have required an intensive care unit bed when none were available or who were judged to be too unstable for transfer by a Med Emergency Department physician. An additional 41 percent of refusals involved patients who would have required subsequent hospitalization when the Med had no vacant ward beds.

4) **"Dumping" permits private hospitals to shift a substantial proportion of their charity health care costs to already crowded, financially strapped public hospitals.** During the summer of 1986 a total of 88/271 patients (33.2 percent) transferred to the Med for primarily economic reasons required emergency hospitalization. Sent during a time when the Med was already operating at or above its functional capacity, these "economic" transfers accounted for an additional 634 bed-days of hospitalization (enough to fill the entire medical/surgical/intensive care capacity of the Regional Medical Center for 2.4 days). Subsequent financial analyses indicate that transfer of these patients directly shifted over $330,000 of uncompensated care from area private hospitals to the Regional Medical Center at Memphis. In addition, patient 'dumping' generated substantial indirect costs by forcing the Med to delay admission of elective paying patients or arrange for their care elsewhere. Limited bed availability also forced the Med to occasionally transfer indigent emergency department patients to neighboring private hospitals. Promise of reimbursement by third party payors or the Med was required by these hospitals prior to accepting any of these patients in transfer.

5) **Despite this screening process, many patients transferred for primarily economic reasons arrive in serious or unstable condition.** By previously published explicit criteria, over 20% of 271 patients transferred for primarily economic reasons were unstable on arrival to the Med ED. Ten patients required emergency surgery and/or intensive care.

6) **To date, COBRA, Tennessee state hearings, adverse local publicity and an ongoing program of directed negative feedback have had limited impact on the magnitude or nature of patient dumping in Shelby County, Tennessee.** Preliminary analysis of 1987 data for the Regional Medical Center at Memphis suggests that there has been little change in practice since last year.

SUMMARY CONCLUSIONS

1) Medically unnecessary transfer of emergency department patients due to inability to pay is a serious and growing problem nationwide.

2) Patient welfare and safety are often jeopardized by precipitous transfer, failure to provide adequate stabilization, failure to establish contact with the receiving hospital and failure to routinely provide relevant medical records.

3) In Tennessee and elsewhere, local and state efforts to regulate and/or stop patient dumping have either been frustrated or have been shown to be largely ineffective.

4) COBRA represents an important federal attempt to limit the worst abuses of patient dumping by requiring emergency departments to provide adequate stabilization and care to patients with emergency medical conditions and women in active labor prior to transfer.

5) The effectiveness of COBRA to date has been extremely limited. This is due, in part to:

   a) Physician and hospital unfamiliarity with the specific requirements of COBRA.
   b) Public hospital reluctance to inform the Health Care Financing Administration (HCFA) of potential violations of COBRA.
   c) HCFA's failure to develop a comprehensive monitoring and reporting system to identify potential violations of COBRA.
   d) HCFA's failure to review potential violations of COBRA in a manner which can be shielded from local political considerations.

6) We recommend that several key elements be addressed in drafting regulations to implement COBRA. They include:

   a) Definitions for terms such as 'appropriate screening exam' and 'stabilization' should be judged against a national standard of care.
   b) Transfer without advance authorization by the receiving hospital should be considered a serious violation of COBRA. Both the transferring physician and the transferring hospital should be held accountable.
   c) Written certification of the patient stability at the time of transfer and the reason(s) for transfer should be specified in writing. When a patient is unstable, certification that the medical benefits of transfer outweigh the risks should also be required. A copy of this certification should be sent with the patient. No unstable patient should ever be transferred from a hospital equipped to provide needed care.
   d) Appropriate medical records must be specified to accompany the patient in transfer.
   e) Duty to treat and responsibility for the patient's condition during transport should clearly rest with the transferring hospital and physician.
   f) Written, informed consent should be obtained from the patient (or legal guardian) prior to transfer and a copy should be sent with the patient.
   g) Monitoring of hospital compliance should be conducted on a periodic basis to insure compliance with the provisions outlined above. This can be done under the auspices of HCFA, the Joint Commission on Accreditation of Hospitals, or possibly Physician review organizations or some other appropriate body. Federal oversight is essential, because the potential for politicization of this process is simply too great to be trusted to administrative review on a state or local level.

7) The Regional Medical Center at Memphis, its medical staff and the authors of this report strongly urge that the Human Relations Subcommittee of the Committee of Government Operations, U.S. House of Representatives strongly support immediate implementation of effective federal regulations to meet the full scope and intent of COBRA.

A NATIONAL PROBLEM

Recent changes in both the health care industry and the nation's economic and political climate have had an adverse impact on the delivery of medical services to the poor. Economic pressures generated by new competitive forces in the health care industry have increased the incentive to transfer patients with inadequate insurance to publicly supported facilities. Unfortunately, recent pressure to cut taxes and spiraling budget deficits have caused local governments and state legislatures to fix or reduce funds available to support public hospitals. At the same time, implementation of the Prospective Payment System for Medicare reimbursement is reducing the margin that used to be available for financing indigent health care. As these forces have begun noticeably to effect the health care industry nationwide, public concern over provision of adequate emergency services to indigent and uninsured persons has grown. (1)

Interhospital transfer has long been considered appropriate when a patient needs specialized care that is unavailable at the transferring hospital. Some also consider inability to pay for hospital services to be an acceptable reason for transfer. While transfer of stabilized patients from private to public hospitals has long been practiced in American health care, the transfer of emergency patients for purely economic reasons (a practice that has come to be termed patient 'dumping') has dramatically increased in recent years (2, 3). Transfers to D.C. General Hospital increased from 169 to nearly 1,000 annually between 1981 and 1984 (4). Likewise, Cook County Hospital in Chicago reported 1295 patients transfers in 1980. By 1983, this total had increased to 6,769. (5)

Recent descriptive studies confirm that many economically motivated interhospital transfers involve seriously ill or injured patients. In 1983, Schiff, Ansell and colleagues studied 467 consecutive cases in which patients were transferred to Cook County Hospital and subsequently admitted to a medical or surgical service. Transferring hospitals identified "lack of insurance" as the primary reason for transfer in 87 percent of the 245 cases for which this information was available. Only six percent of patients provided written, informed consent prior to transfer. Many of these transferred patients were seriously ill; 24 percent were found to be unstable on arrival by explicit clinical criteria. Twenty-two percent required intensive care within 24 hours of admission to Cook County Hospital. (5)

In 1984, Himmelstein and coworkers documented 458 patient transfers from area private hospitals to Highland General Hospital in Oakland, California. Sixty-three percent of these patients had no medical insurance. Over half of patients transferred required emergency hospitalization, and 22 (five percent) required intensive care. In 33 cases, transfer was judged to result in potentially dangerous delays to care (6).

In 1985, the National Association of Public Hospitals asked member institutions to report total patient transfers to their emergency departments over a two week period. A total of 1066 interhospital transfers were noted by 26 member hospitals. In more than 70 percent of cases, transferred patients required emergency care on arrival. Over half of 471 patients who required emergency care and hospitalization lacked any form of medical insurance. (7)

In 1983, problems with patient dumping prompted officials at Parkland Memorial Hospital in Dallas, Texas to adopt a strict transfer policy. Parkland receives approximately 150 patient transfers per month, many of whom are sent due to lack of adequate insurance. Parkland established strict clinical and financial criteria for determining the appropriateness of transfer and required transferring hospitals to call for approval prior to initiating transfer. Following implementation of this policy (1984 - 1985), transfers without prior notification decreased from 28 percent of the total to 17 percent. However, 22 patients were sent despite refusal by Parkland and total patient transfers, the number of transfers requiring hospitalization and total deaths in the Parkland emergency room did not change significantly following adoption of this policy. (8)

The impact of "patient dumping" on the operation of the nation's public hospitals should not be underestimated. Nationally, a substantial proportion of indigent health care has been traditionally provided by publicly supported facilities. These institutions are now being forced to accept an even greater burden of charity care through patient dumping. Dumping, therefore, not only complicates (and sometimes jeopardizes) the care of poor people, it also puts an even greater strain on already overloaded public hospitals, further threatening their survival. (2)

The private sector of health care industry has shown little interest or willingness to restrict the transfer of patients for purely economic reasons. The strongest opposition to regulations by the Texas Board of Health to regulate dumping in that state has been lead by investor owned, for-profit hospitals. (9) In Tennessee, legislative action and state regulations have been vigorously fought by the Tennessee Hospital Association. Community based programs of voluntary restraint have not worked; protests from public hospitals regarding individual abuses are generally ignored. (3)

PATIENT TRANSFERS IN THE MID-SOUTH

The Regional Medical Center at Memphis (also known as 'the Med') is a 450 bed, adult, acute care hospital supported in part by the government of Shelby County ,Tennessee. In addition to its historic mission to provide health care to all citizens of the county without regard to their ability to pay, the hospital also provides highly specialized services for care of major trauma, burns, high risk obstetrics and neonatal intensive care. The Emergency Department at the Med also provides a comprehensive range of adolescent and adult emergency services to all patients requiring emergency medical care, regardless of their ability to pay. Unlike the Med's special care units, however, the services of the Med Emergency Department are also readily available in all major private hospital emergency departments in Shelby County and the Mid-South.

Between March 1 and May 31, 1986, physicians in the Med Emergency Department informally noted in an ER log all ambulance transfers from private hospitals. The transferring physician's stated reason for transfer was also recorded in a majority of cases. Many of these requests were also tape recorded. While these figures were informal and incomplete, a total of 142 ambulance transfers were noted during this 92 day period. In 106 cases (74.6%), "lack of money", "lack of insurance" or "Shelby County indigent" was stated by the requesting physician as the primary reason for transfer. In the bulk of remaining cases, no reason was recorded.

Based on these figures and a small number of serious incidents involving transfer of extremely unstable patients for purely economic reasons, we conducted a detailed audit of Emergency Department patient transfers to the Regional Medical Center at Memphis during the subsequent three month period (June 1, to August 31, 1986). (10) In November of 1986 data from this audit was presented to the Tennessee Board for Licensing Health Care Facilities, which was (and still is) considering regulations to control patient dumping in Tennessee. Intensive coverage by the local news media and discussions within the Memphis/Shelby County Medical Society followed. In response to problems identified by this 1986 audit, a more aggressive approach to dealing with inappropriate transfers was implemented by the physician staff of the Med Emergency Department. In order to assess the impact of these initiatives, an identical audit of emergency department transfers between June 1 and August 31, 1987 is currently in progress.

STUDY GOALS (Summer, 1986 Audit)

1. To describe the number and type of emergency department transfers to the Regional Medical Center at Memphis over a three month period and identify the proportion of these due to inability to pay.
2. Identify the number and type of patients transferred for economic reasons who are unstable at the time of transfer.
3. Identify and assess the magnitude of emergency department transfers involving patients sent from other hospital emergency departments without preceding telephone authorization.
4. Assess the clinical and financial impact of "dumping" on patients by determining the delay in medical care and by calculating the additional costs of ambulance and emergency department service to patients transferred due to inability to pay.
5. Assess the impact on costs and additional bed utilization caused by "economic transfers" to the Regional Medical Center, both in absolute terms and as a proportion of the hospital's total provision of indigent care.

STUDY GOALS (Summer, 1987 Audit - In progress)

6. To reassess all of the factors outlined above, and by doing so, to assess the impact of COBRA, state hearings, public opinion and directed feedback on the practice of Emergency Department patient "dumping" to the Regional Medical Center at Memphis.

CASE IDENTIFICATION

During both audit periods (June 1 - August 31, 1986 and June 1 - August 31, 1987) we attempted to identify all patients transferred to the Emergency Department of the Regional Medical Center at Memphis from local and regional hospital emergency departments (ED's) and affiliated free-standing emergency centers (EC's)

Patients sent from county health department neighborhood clinics, private physician offices and nursing homes were not included. U transfers from other hospital were also not included. ED and EC transfers were identified by one or more of the following methods:

1. Documentation of all telephone requests for transfer and all accepted transfers.
2. Identification of the point of origin for all patients arriving by ambulance to detect all sent from another hospital ED or affiliated free-standing emergency center.
3. Brief interviews with all ambulatory patients presenting to the Med ED assessment desk (triage) to identify all who were referred to the Med on a "same-day" basis from other area emergency departments. (Note: patients who received care at another ED but came to the Med for further care on their own accord were not included).
4. All Med ED patients records were also carefully reviewed to identify patients not otherwise noted by one of the three mechanisms outlined above.

DATA RECORDED

Internal Medicine residents on duty in the Regional Medical Center ED handled all telephone requests for transfer. For each call received, they systematically recorded the physician and hospital requesting transfer and the sending MD's primary reason for requesting transfer. If a transfer request was denied, the reason for refusal was also noted.

The day following transfer and subsequent emergency care, copies of all Med ED records and copies of any documents received from the transferring hospital were collected for later review. A copy of the discharge summary was subsequently obtained in each case which required emergency hospitalization.

A list of all study cases was also submitted to the business office of the Regional Medical Center at Memphis for computation of total ED and hospital charges. Physician fees at the Med are billed separately and were not included. Hospital collections from each patient were tabulated beginning six months following ED care and/or subsequent hospital discharge. Unpaid bills six months following discharge were assumed to represent uncollectable accounts.

DEFINITIONS

- A transfer was considered 'authorized' if telephone contact was made with a staff or resident physician at the Regional Medical Center at Memphis prior to transfer and the transfer request was accepted. Transfers without a preceding telephone call, transfers despite refusal and transfers initiated prior to a notifying telephone call were considered to be "unauthorized".
- Transfers were considered to be made for primarily economic reasons whenever the physician requesting transfer identified "lack of insurance", "no money", or "Shelby County indigent" as the primary reason for transfer. Patients sent to the Med ED without prior telephone contact or authorization were also presumed to have been transferred for primarily economic reasons.

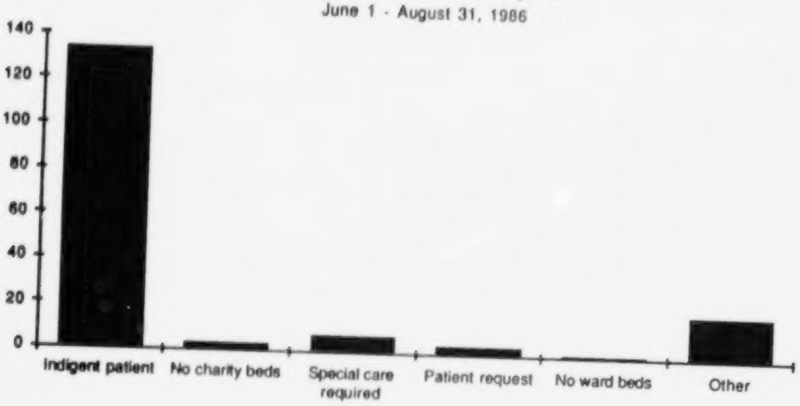
RESULTS

TABLE 1
TOTAL INTERHOSPITAL AND EMERGENCY DEPARTMENT TRANSFERS TO THE REGIONAL MEDICAL CENTER AT MEMPHIS, JUNE 1, 1986 TO AUGUST 31, 1986

SPECIAL CARE AREAS:		
Trauma Center	199	(22.9%)
Burn Center	5	(0.6%)
Obstetrics	342	(39.4%)
Neonatal Intensive Care	42	(4.8%)
EMERGENCY DEPARTMENT	280	(32.2%)
TOTAL*	868	(100%)

*Total excludes inpatient transfers directly admitted to inpatient services other than the special care services noted above.

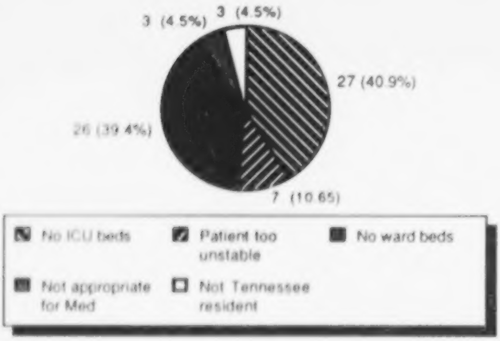
During the 1986 three month study interval, transfers to the Med Emergency Department accounted for less than a third of emergency interhospital transfers to the Regional Medical Center at Memphis. While many of the 546 patients transferred to the hospital's burn, trauma and obstetric units may have been sent for primarily economic reasons, we assumed for purposes of this analysis that all patients transferred directly to these areas truly required the highly specialized services they provide. The magnitude of these numbers, however, further reflects the importance of the Regional Medical Center at Memphis for providing regional centers of excellence for the care of major trauma, burn, high risk obstetric and neonatal ICU patients, regardless of their ability to pay.



Reason for Transfer Request

June 1 - August 31, 1986

Advance telephone contact was made with a physician in the Med Emergency Department in 168 cases. In 137 cases (81.5%), 'inability to pay' or 'no charity beds available' was explicitly identified by the transferring physician as the primary reason for transfer. In 76 cases, both the time the call was received and the time the patient arrived were recorded. By this measure, definitive care in these 76 cases was delayed an average of 4.1 hours per case.



Refused Transfer Requests by Reason for Refusal
June 1 - August 31, 1986
n = 66

In 66 of168 cases (39 percent) requests for transfer were refused by physicians of the Regional Medical Center at Memphis. In 34 of these 66 cases (52 percent), the patient was judged to be too unstable for transfer or the patient required an intensive care unit bed when none was available at the Med. Transfer of unstable patients was not refused if necessary services for the care of the patient were unavailable at the referring hospital or its parent facility. In all cases in which transfer was refused because the patient was too unstable, necessary services for care of the patient were readily available at the requesting hospital to paying patients. In these cases, the request for transfer was motivated by the patients' inability to pay.

In most of the remaining cases (39 percent), lack of vacant ward beds at the Med was noted to be the primary reason for refusal. During the summer months, the daily bed census of the Med routinely exceeds 95-98 percent. This situation became especially critical in August of 1986, when daytime bed counts frequently exceeded 100 percent of the hospital's staffed capacity. A total of 38 (58 percent) refusals were recorded in the month of August alone.

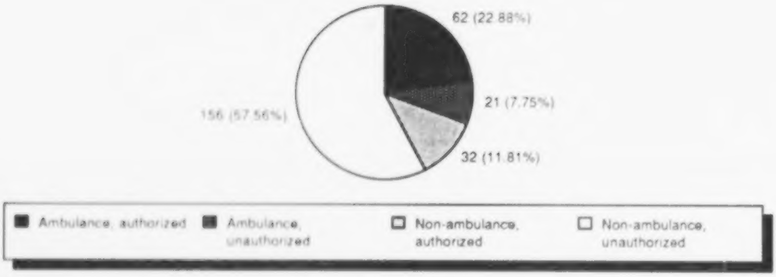
ECONOMIC TRANSFERS VS. THE GENERAL MED ER POPULATION
A DEMOGRAPHIC ANALYSIS

		STUDY (N=271)	GENERAL ED (N=5694)	P
SEX				
	Female	144 (53%)	3088 (54%)	.72
	Male	127 (47%)	2606 (46%)	
RACE				
	Black	191 (70%)	4608 (81%)	.0001
	White	79 (29%)	1070 (19%)	
	Other	2 (1%)	12 (<1%)	
AGE				
	Mean	31.9 (±14.3)	35.4 (±15.6)	.0003
	10-19	47 (17%)	555 (10%)	.0003
	20-29	102 (38%)	2032 (36%)	
	30-39	55 (20%)	1389 (24%)	
	40-49	26 (10%)	654 (11%)	
	50-59	27 (10%)	506 (9%)	
	60-69	11 (4%)	317 (6%)	
	70 +	3 (1%)	241 (4%)	
COUNTY				
	Shelby	250 (92%)	5424 (95%)	.02
	Other	21 (8%)	266 (5%)	
ADMITTED				
	Yes	87 (32%)	592 (10%)	.0001
	No	184 (68%)	5050 (90%)	
CARRIER				
	Self Pay	182 (67%)	3154 (56%)	.0001
	Medicaid	60 (22%)	1234 (22%)	
	Medicare	10 (4%)	481 (8%)	
	Private	2 (1%)	593 (10%)	
	Other	17 (6%)	207 (4%)	

Patients sent to the Med ED tended to be younger and were more frequently white than the hospital's general ED population. Group severity of illness and/or injury was also greater, since patients transferred to the Med were more than three times more likely to require emergency hospitalization. A substantially larger percentage of patients transferred for economic reasons lacked any form of health insurance.

Economic Transfers by Type

June 1 - August 31, 1986
n = 271



Despite attempted telephone screening, a total of 280 patients were transferred to the Regional Medical Center at Memphis Emergency Department. In 177 (64 percent) of these cases, the patient was sent by ambulance or private automobile without prior telephone contact or authorization. Few patients transferred without prior authorization arrived with relevant medical records. We believe that patients sent without prior telephone contact were referred for primarily economic reasons. If this is indeed the case, then 271 of these 280 emergency department patients (97 percent) were either implicitly or explicitly transferred to the Med due to inability to pay.

MOST COMMON MAJOR MEDICAL PROBLEMS OF 'ECONOMIC TRANSFERS'

June 1 - August 31, 1986

(N=271)

	N	%
Laceration/Blunt Trauma	24	8.9
Fracture Upper Limb	21	7.7
Cellulitis/Abcess	14	5.2
Acute Abdominal Pain	14	5.2
Drug Overdose	12	4.4
Pelvic Inflammatory Disease	9	3.3
Seizures	8	3.0
Acute Psychosis	7	2.6
Pyelonephritis	7	2.6
Facial Fracture(s)	7	2.6
Chest Pain/MI	7	2.6
Pneumonia	6	2.2
Asthma/COPD	6	2.2
Pancreatitis	6	2.2
Uterine Hemorrhage	6	2.2
Gastrointestinal Bleeding	5	1.8
Incomplete Abortion	5	1.8
Acute CVA	5	1.8

Other Diagnosis Included: Hypertensive Crisis (4), CHF (3), DKA (2), Kidney Stone (2), and many others.

The most common diagnoses of patients sent to the Med ED from neighboring private hospital are extremity fractures and complex lacerations. Almost all of these patients arrived by private automobile, generally without advance notification. Most were simply splinted or bandaged at the original facility and then sent to the Med for definitive care. One should note, however, that a substantial number of these transfers involved patients with far more serious illnesses, including: chest pain/myocardial infarction (heart attack), seizures, drug overdose, acute abdominal emergencies and diabetic ketoacidosis. In all of these cases, "dumping" subjected patients to the hazards of a medically unnecessary transfer and introduced additional delays to definitive care.

ECONOMIC TRANSFER STUDY:
SEVERITY OF ILLNESS CRITERIA
(AT TIME OF ARRIVAL IN ED)

VITAL SIGNS

a. Heart Rate > 140 or < 50

b. Respiratory Rate > 28 or < 8

c. BP Diastolic < 40 or > 130

d. Temperature > 94 or > 102

CARDIOVASCULAR

a. Chest pain with suspicion of ischemia

b. Rhythm: PSVT or flutter/fib with heart rate ≥ 140, heart block (second degree mobitz II or greater) ventricular tachycardia or high grade ectopy

c. IV antiarrhythmics or IV pressors (eg, dopamine, dobutamine, morepinephrine, lidocaine, procainamide, bretyllium) during transport

RESPIRATORY

a. Hypoxia ($PO_2 \leq 60$ mm Hg regardless of FIO_2)

b. Resp rate ≥ 28 or intubated or "resp distress"
Resp rate ≤ 8 or "resp failure"

c. Airway obstruction with stridor

d. Respiratory acidosis ($pH < 7.30$ with $pCO_2 > 45$)

INFECTIONS

a. Meningitis (suspected or diagnosed)

b. Sepsis (suspected or diagnosed)

c. Active infections in immunocompromised hosts. (Cancer patients, leukemia, AIDS)

SHOCK

a. $BP < 100$, with tachycardia ($P \geq 100$), other findings of hypoperfusion: decreased mentation, cool extremities, dusky extremities, evidence of organ dysfunction

METABOLIC

a. DKA ($pH < 7.30$, $HCO_3 < 14$ with $BG > 200$ and Ketonuria)

b. Hypoglycemia $BG < 40$, chemstrip ≤ 40 with mental status changes

c. Hyperglycemia: $BG > 800$

d. $K \leq 3.0$ or ≥ 6.0

e. Acidosis ($pH < 7.30$) (any cause)

f. Drug toxicity (Dig level > 2.0, theo > 20.0, Dilantin level > 30.0, $Li > 2.0$, drug screen positive of tricyclic antidepressants with suspicion of overdose)

g. $Na > 150$ or $Na < 125$

NEUROLOGIC

a. Altered mental status (lethargic, confused, comatose, unable to answer questions)

b. Acute CVA, new focal neurologic deficits, non-traumatic

c. Focal neuro deficits or altered mental status secondary to trauma

OB/GYN

a. Suspected ectopic pregnancy

b. Active labor

HEMATOLOGY

a. Severe anemia (Hct <25% with evidence of actual blood loss per NG tube, rectal bleeding, and/or vaginal bleeding)

b. Blood transfusion during or prior to transport

c. Active blood loss upon arrival of >500cc with evidence of shock regardless of hematocrit

GASTROENTEROLOGY

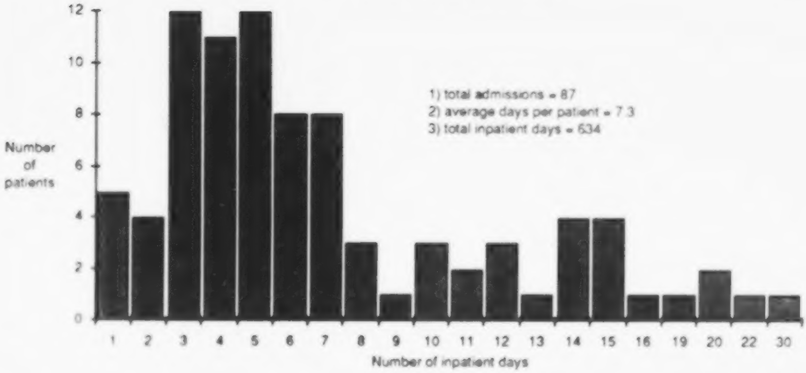
a. Active upper/lower GI bleeding

b. Possible acute abdomen (abdominal tenderness, with signs of acute peritonitis) or pancreatitis.

All ER charts of patients transferred to the emergency department of the Regional Medical Center at Memphis during the summer of 1986 were reviewed by a team of nurses from the hospital's quality assurance departments to identify patients who were seriously ill and/or unstable on arrival to the Med. ER documentation was compared to a modified list of previously published explicit criteria (see appendix A and ref 3) to identify these cases. Based on this review, a total of 74 out of 271 patients (27 percent) transferred for economic reasons were found to be unstable by explicit criteria. While 46 of these 74 patients were transferred by ambulance, 38 arrived via private automobile.

Length of Stay for Admitted Patients

June 1 - August 31, 1986



A total of 90 patients required emergency hospitalization (87 at the Med and three at Memphis Mental Health Institute). Ten required emergency surgery and/or intensive care. Given the extremely heavy demand for ICU services experienced by the Med during this summer audit, it is likely that some patients admitted to hospital ward beds would have otherwise been admitted to intensive care. During this period of extreme inpatient crowding, Emergency Department patients transferred for primarily economic reasons accounted for an additional 634 bed days of hospitalization (enough to fill the entire medical/surgical/ICU capacity of the Med for 2.4 days).

Hospital crowding was at times so extreme during the 1986 study interval that the Regional Medical Center at Memphis Emergency Department was forced to transfer out a small number of patients for care in private hospitals. Guarantee of payment by the Med or third party payors was required by private hospital administrators prior to accepting any of these patients in transfer.

ED PATIENT 'DUMPING' IN THE MID SOUTH:

UNNECESSARY MEDICAL CHARGES DUE TO TRANSFER FOR ECONOMIC REASONS

N = 271 CASES

AMBULANCE TRANSFERS: ($75.00 X 83 CASES)	$6,225
MED ED CHARGES (271 ED TRANSFERS)	$46,205
TOTAL CHARGES	$52,430
AVERAGE EXTRA CHARGES PER CASE	**$194.00**

A single private ambulance company provides almost all of the interhospital transfers in Memphis. According to a company executive, the transferring institution rarely pays the costs for transporting patients sent to the Med for primarily economic reasons. As a result, the patient is billed $75.00 by the ambulance company. During our study, patient charges for a second Emergency Department evaluation at the Med totaled over 46 thousand dollars. Based on these figures, decisions to transfer these 271 patients due to inability to pay directly increased their health care charges by 194 dollars per case.

ED PATIENT 'DUMPING' IN THE MID SOUTH:

TOTAL UNCOMPENSATED MEDICAL CARE TO 267 ED PATIENTS TRANSFERRED FOR ECONOMIC REASONS*

	N	%	TOTAL CHARGES	COLLECTIONS+	UNCOMP. CARE
MEDICARE	12	4.5%	$31,312	$19,379.28	$11,932.72
MEDICAID	59	22.1%	$87,219.76	$50,304.42	$36,915.40
PRIVATE INSURANCE	19	5.0%	$30,629.84	$3,463.45	$27,166.39
SELF PAY	177	66.3%	$263,538.78	$1,868.46	$261,670.32
TOTAL	267	100.0%	$412,700.38	$75,015.61	$337,684.83

*Total excludes 9 patients transferred for medical reasons and four for whom no billing data could be found.

+Receipts six months following ED visit and/or subsequent hospitalization.

Total charges for care of the 271 Emergency Department cases transferred to the Regional Medical Center at Memphis for economic reasons exceeded four hundred twelve thousand dollars. Collections 6 months following the end of the study totaled seventy five thousand dollars. Transfer of these 271 patients to the Regional Medical Center at Memphis therefore shifted the need over three hundred thirty thousand dollars in uncompensated care from local private hospitals to the Regional Medical Center at Memphis.

Given the extreme inpatient crowding noted earlier in our report, transfer of these patients generated substantial indirect costs as well. During the summer of 1986, the Regional Medical Center at Memphis was repeatedly forced to delay or defer elective admission of paying patients due to lack of available beds. By postponing or redirecting admission of elective patients, the Med risks losing its final, critically needed source of operating revenue - the paying patient (11).

A conservative estimate of the annual direct costs of patient "dumping" to the Med is one million dollars. This figure is less than two percent of the Med's annual total for uncompensated care (currently reported to exceed seventy three million dollars). Clearly the Med provides a massive amount of free and reduced cost care to citizens of Shelby County and neighboring counties in the Mid South. In part, as a result of this level of uncompensated care, the Regional Medical Center at Memphis reported a net operating loss of three million dollars in 1985. In 1986, net losses of the Med exceeded seven million dollars.

In contrast, in 1985 the major private hospitals in Shelby County reported combined net earnings (after allowances for charity care) of more than sixty two million dollars. Cumulative financial data for 1986 is not yet available.

(Cont'd)

Newsweek recently commented on the financial health of a major Memphis based hospital system in its January 26, 1987 issue, titled "The Revolution in Medicine":

> "Nonprofit hospitals can be more profitable than for-profit hospitals. Baptist Memorial Hospital of Memphis, the nation's largest nonprofit, had a 16.2 percent profit ratio in 1984, according to documents obtained under the Freedom of Information Act by the Memphis Commercial Appeal. The similar figure that year for HCA, the largest for-profit hospital chain was 8.5 percent; for Humana Inc., 9.9 percent; for At&T, 4.1 percent". (12)

In 1984, this 16.2 percent profit amounted to net revenues of over thirty two million dollars for Baptist Hospitals (which includes Baptist Memorial Hospital - Central and Baptist Memorial Hospital East and related corporate holdings). In 1985, net revenues were down, but still exceeded seventeen million dollars. For these same two years, the Regional Medical Center at Memphis reported net losses of six million and three million, respectively (13).

During the summer of 1986, the two Memphis hospitals in the Baptist system transferred a total of 34 patients to the Med ED for primarily economic reasons.

In the May 14, 1987 issue of the Memphis Commercial Appeal, reporter Steve Tompkins noted that Methodist Health Systems, Inc., (another large not-for-profit hospital system based in Memphis) reported net earnings of 17.1 million dollars for 1986. This figure represented an increase of 39% over net earnings for the previous year. Methodist Health Systems also noted that its three Memphis hospitals and seven regional hospitals provided 16.6 million dollars in charity care for 1986 up from 13.4 million in 1985. In response to these figures on charity care, John T. Casey, President and CEO of Methodist Hospital Systems said, "I don't want to pat ourselves on the back too much about that, because frankly, that's more than we feel we ought to be doing" (14).

The three Memphis hospitals of the Methodist Hospital System (Methodist Central, North and South) transferred 120 emergency department patients to the Regional Medical Center at Memphis for primarily economic reasons during the Summer of 1986.

Since the end of the summer of 1986, ER patient dumping has continued. Data from our summer 1987 audit is currently being analyzed.

Documented Authorized Emergency Department* Transfers to the Emergency Department of the Regional Medical Center at Memphis
June 1986 - May 1987

June	49
July	50
August	28
September	36
October	15**
November	37
December	40
January	9**
February	24**
March	47
April	65
May	43
Total	443

*Health department, nursing home and doctors office referrals not included.
**Data recording incomplete

Note: Approximately two additional unauthorized transfers are received for every patient sent with prior telephone authorization. This suggests that the actual number transferred over this 12 month period has probably exceeded 1,300 patients.

AN INSTITUTIONAL RESPONSE

Concurrent with the accumulation of data during the summer of 1986, the medical staff of the Emergency Department of the Regional Medical Center at Memphis began a more aggressive program of responding to problem transfer cases. This largely consisted of specific, formal written complaints to the directors of local emergency departments and their hospital administrators. Testimony on the state level before the Tennessee Board for Licensing Health Care Facilities and extensive news coverage by local print and television media further dramatized the problem of emergency department patient "dumping". In August of 1986, the provisions of COBRA dealing with the transfer of seriously ill or injured patients and women in active labor became law.

STATE REGULATORY EFFORTS TO DATE

During the 1985-86 session of the General Assembly of the State of Tennessee, a bill (S.B. 1410) intended to stop the transfer of patients for 'purely economic reasons' was passed and signed into law. Unfortunately, prior to passage, lobbyists for the Tennessee Hospital Association were successful in efforts to have key language in the bill amended.

In a June 12, 1986 memorandum to member institutions, Charlie Cato, Corporate Counsel for the Tennessee Hospital Association noted this effort as follows:

> "Significantly, we were able to amend the bill (S.B. 1410) to provide that such (transfer) regulations deal only with transfers of inpatients, thus excluding consideration of emergency room cases where no inpatient relationship has been established . . . Although we cannot speak to the final form which the regulations will take, we hope they will turn out to be far less burdensome that the Federal Act (COBRA) summarized above".

The state's Board for Licensing Health Care Facilities was charged with writing regulations to implement the legislative intent of this Bill. In two hearings before the Board (one in November 1986 and one in January 1987), representatives of the Regional Medical Center at Memphis and grass-roots organizations from across the state presented compelling evidence that emergency department patient "dumping" was a serious problem in Tennessee. When first presented with this evidence, a majority of the Board declined to extend regulatory protection to emergency department patients, arguing that to do would exceed their authority under the "legislative intent" of the new law.

This decision prompted harsh criticism from the original sponsor of the legislation, State Senator John Ford (D-Memphis). Ford requested a formal opinion from the State Attorney General and demanded that the Board reconsider its decision. Given AG assurance that regulation of emergency department transfers was indeed within the Boards authority, the Board unanimously voted last spring to reverse its earlier decision and extend regulatory protection to emergency department patients. Unfortunately, under pressure from the Tennessee Hospital Association, the Board voted to postpone final consideration of regulatory language pending four additional hearings in the largest cities of Tennessee. These are currently scheduled for August and are primarily intended to provide private hospitals in the state an extended period of time to examine the proposed regulations and respond to them. More than a year after SB 1410 was passed, Tennessee is no closer to having effective regulations to stop patient "dumping".

CASE STUDIES IN PATIENT "DUMPING"

The following eight cases are selected from files in the emergency department of the Regional Medical Center at Memphis (The Med). While the names of the patients, the transferring hospital and the date of transfer have been omitted, all of the information described is true. Quoted comments are drawn from transcripts of taped conversations between transferring physicians and ER residents of the Regional Medical Center at Memphis. Comments in parentheses ( ) are intended to simplify confusing medical terminology. All eight cases occurred within the past nine months.

CASE #1
Diabetic Ketoacidosis

On a recent morning, a young white male with insulin-dependent diabetes came to the emergency department of a large Memphis private hospital with rapid breathing, nausea, vomiting and chills. Initial laboratory tests revealed he was in life threatening diabetic ketoacidosis. Within an hour of the patient's arrival, a physician in the hospital's emergency department contacted the Med by telephone to state "I've got a gentleman over here, a twenty year old white male who is a Memphis city resident, who is in diabetic ketoacidosis and he needs to be hospitalized and he doesn't have insurance". Vital signs, pulse, respirations and blood pressure were reported to the Med but no other evidence of serious ketoacidosis was volunteered. The Med physician requested that the patient receive addition intravenous fluid prior to transfer. Immediately following additional fluid, the nurses at the transferring hospital sent the patient by ambulance to the Med without further examination and without final authorization for transfer. The patient arrived at the Med in extremely critical condition with ongoing ketoacidosis and possible sepsis. Following an intensive 90 minute period of stabilization in the Med ER, he was admitted to a bed in the hospital's medical intensive care unit.

CASE #2
Tricyclic Antidepressant Overdose

At a suburban Shelby County hospital, a young white male was brought to the emergency department following an intentional overdose of tricyclic antidepressant medication, a class of drugs that can cause coma, seizures, cardiac instability and death. During initial treatment he became combative and was placed in police custody under Tennessee Code Annotated 33-6-103, which deals with emergency commitments for psychiatric evaluation. A call was placed to the Med ED requesting transfer since the patient was now a "under arrest". Noting that the patient had ingested a potentially lethal amount of tricyclic drugs, the Med ER resident informed the requesting MD that transfer could not be accepted because the Med had no vacant intensive care unit beds for necessary cardiac monitoring. The transferring MD agreed not to initiate transfer. A few moments later, an ER nurse at the transferring hospital called back to inform the Med resident that while the previous call was taking place, the patient had been loaded into an ambulance and was enroute to the Med. A short time later, the patient arrived. Severely obtunded and hypotensive, he was stabilized in the ER until an overflow ICU bed could be prepared. Perhaps coincidentally, it was also noted that the patient had no health insurance.

CASE #3
Meningitis

Hospital affiliated but free standing emergency centers can also be the source of serious patient "dumping". Recently, one such center called the Med ER seeking to transfer a young man with no insurance and "possible meningitis". At the time the call was received, the Med's bed census was above 98% of capacity and the few available beds were exceeded by the total number of emergency room patients on hand who were going to require admission. Having been told not to accept any transfers because the hospital was full, the Med ER resident refused to authorize transfer and suggested that the patient be admitted to the large private hospital which supports the emergency center. Apparently, the center's director then called the Med's admissions office and found out about these few unoccupied beds. The director then called back and accused the ER resident of lying. During a subsequent conversation a short time later with the Med ER director, this physician repeated his charge and stated it was the Med's obligation to care for the poor of the county. Admission to his parent hospital was not appropriate, this physician added, because the young man and his family could not pay. He then stated that the patient had been discharged in the custody of his parents and that they had been instructed to come to the Med. About an hour later, the patient arrived via private automobile. Examination revealed a delirious young man with a stiff neck, a severe headache and a fever of 104. An emergency CAT scan was obtained and a spinal tap was positive for meningitis. Shortly after arrival in the Med ER the patient had two generalized seizures and required emergency endotracheal intubation and mechanical ventilation. He was then admitted to an intensive care unit on multiple antibiotics. *Seven days later, he died.*

Comment: (Cases 1, 2 and 3)

> One of the most important elements of the COBRA law governing interhospital transfers is the requirement that contact must be established with the receiving hospital and that authorization must be granted prior to sending the patient in transfer. Precipitous, unauthorized transfers can be particularly dangerous to the patient and potentially disruptive to the receiving hospital if it is fully occupied or lacks proper facilities for the care of the patient. If and when such cases occur, both the transferring hospital and the transferring physician should be held accountable.
>
> Perhaps the most difficult part of writing regulations for COBRA will involve defining terms which are central to the scope and intent of the law. Concepts like "appropriate screening exam" and "stabilization" mean different things to different people. In the first of these three cases, a formal complaint was disregarded by the transferring hospital on the grounds that the patient had received "all necessary treatment" and was in "stable condition" at the time of transfer. The Med has since requested Medical Society review, but no formal mechanism currently exists in Shelby County to examine such cases. We suggest that documented medical care in such cases be examined in light of the commonly accepted standard of care practiced in the state in which the transfer occurred. Since dumping is often an interstate problem, it may prove even more desirable to invoke a national standard of care. Both standards are commonly applied in malpractice cases and either should be appropriate to an analysis of the quality of care during hospital transfers. We also recommend that a violation be considered to occur whenever a patient is placed in serious jeopardy by a medically unnecessary transfer, regardless of whether or not the patient actually suffers an adverse outcome as a result.

CASE #4

Painful Sickle Cell Crisis

A young black male with sickle cell anemia presented to a neighboring private hospital with severe joint and bone pain consistent with painful crisis. He had no health insurance and was not covered by Tennessee Medicaid. Rather than receiving a prolonged course of intravenous fluids and pain medication (standard therapy for crisis pain) he was given a short course of fluids and a single shot of pain medication. His discharge instructions read 'Home - if no better in 2 - 3 hours, go to Med'. The patient subsequently found his way to the Med Emergency Department and received 9 hours of additional treatment.

CASE #5

Acute Myocardial Infarction (Heart Attack)

A woman hospitalized in the coronary care unit of a large Memphis private hospital for seven days was discharged home because her insurance had run out. At the time of discharge she was advised by her private physician that if she began to experience chest pain she should seek immediate medical attention at the Regional Medical Center at Memphis. Shortly following discharge, she developed severe chest pain and came to the Med. In the Med ER she was stabilized and subsequently admitted to an intensive care unit where she was diagnosed as having an acute myocardial infarction (a heart attack). A formal complaint to the transferring hospital was dismissed with the comment that discharge was a "medical decision" and as such "did not involve an employee or agent of the (transferring) hospital".

Comment: (Cases 4 and 5)

> COBRA does not offer protection to patients who are not formally transferred but simply discharged in unstable condition and told to seek help elsewhere. If the current provisions of COBRA are aggressively enforced, inappropriate discharges such as these may occur more frequently in the future.

CASE #6
Bowel Obstruction

A 59 year old woman with two recent abdominal operations returned to the hospital where her most recent surgery had been performed only 16 days earlier complaining of severe abdominal pain. Covered only by Tennessee Medicaid, she had exhausted her days of eligibility during her two prior hospitalizations. Despite *being diagnosed as having recurrent small bowel obstruction* (a complication of her recent surgery) an administrator of the hospital refused to allow her to be readmitted. In two separate discussions with the transferring physician, the patient refused to agree to transfer to the Regional Medial Center at Memphis. Following additional persuasion, she reluctantly agreed. Necessary abdominal surgery was subsequently performed at the Med.

Comment: (Case 6)

> The need for patient consent is not clearly addressed in COBRA, other than in cases involving an unstable patient who demands to be transferred. We believe no patient with an emergency condition should be forced to accept transfer without informed consent.

CASE #7
Cardiac Arrest

A physician working in a small hospital in Arkansas recently called the Med ED resident late one night and said, "I have a patient, she's indigent and I don't know if you'll take her or not". The patient was a Jehovah's Witness and had severe anemia from chronic blood loss. When asked why admission was not considered appropriate to his own hospital, the transferring physician replied, "We admitted her to the hospital, but she doesn't have any money and she will become an indigent". Since the patient was not a Shelby County resident, the transferring physician was asked to contact other major private hospitals in Memphis to see if any would accept the patient before calling back. A short time later the doctor called back to state that no neighboring hospital in Arkansas and no private hospital in Memphis would accept the patient. He added that the family had "borrowed $300 to pay an ambulance to get her down there (to Memphis)". Asked if the patient was safe to transfer, the transferring physician replied "Yeh, she will be stable, they can give her O2 (oxygen) on the way".

Given reason to conclude that emergency transfer of an apparently stable patient was being requested for primarily economic reasons, the Med ED resident delayed accepting transfer for ten minutes pending authorization by his ED director. Upon calling back the referring physician to clarify whether transfer was for medical or economic reasons, the resident was shocked to learn the patient had just sustained a cardiac arrest. An air ambulance helicopter was immediately dispatched but the patient died prior to transfer.

CASE #8
Intracranial Hemorrhage

Late one night the Med ED was requested to accept in transfer a patient with elevated blood sugar (diabetes), "somewhat elevated" blood pressure and a single episode of seizure activity. Transfer was requested to the Med because the patient was a "Shelby County indigent". At the time transfer was requested, the Med had no vacant ICU beds. However, the transferring physician assured the Med ED resident that the patient was stable for transfer. When the transferring nurse called Med ED nursing to give additional clinical information, the Med ED resident became more suspicious and recontacted the referring physician to remind him that the Med could not accept a patient who might require intensive care. The ED resident was again told that the patient was stable.

On arrival in the Med ED, the patient was noted to be delirious and combative, with a blood pressure of 230/130 mg/Hg (extremely elevated). Immediately following arrival she had another seizure, then stopped breathing. Following emergency endotracheal intubation, she was placed on a respirator and given massive doses of medications to control recurrent seizure activity. She was held in the ER on a respirator until an overflow intensive care unit bed could be staffed. She died five days later.

COMMENT: (Cases 7 and 8)

Both of these cases demonstrate the limitations of 'telephone screening' to detect unstable patients prior to transfer. Screening will only be as effective as the quality of information volunteered at the time the transfer is requested. If the patient from Arkansas had been accepted at the time the original call was received, she would have died in the ambulance. We recommend that regulations based on COBRA require not only contact with the receiving hospital, but also accurate and complete exchange of information. We also recommend that in all cases of interhospital transfer, the sending physician should be required to certify either that the patient is stable and able to be transferred without significant risk, or that the medical benefits of transfer for specialty care outweigh the risks of transferring an unstable patient (eg, a referral to a trauma center). The reason for transfer should also be specified. In cases in which a patient is sent without proper documentation, we recommend that a presumption be made that the transferring physician judged the patient to be stable. In any case, patient assessment, stabilization and determination of appropriateness of transfer should be clearly identified as the duty of the hospital initiating transfer.

POLICY RECOMMENDATIONS

In conclusion, we believe that several key elements can and should be addressed in drafting regulations to implement COBRA. They include:

1. Clear requirements for evaluation, stabilization and care prior to transfer, judged against a state or national standard of care.
2. Required contact with the receiving hospital, adequate exchange of accurate information and required authorization prior to transfer. In the event of violations, both the transferring hospital and the transferring physician should be held accountable.
3. Physician certification of the patient's condition at the time of transfer and the primary reason for transfer should always be noted in writing. Records should be kept. If transfer of an unstable patient is needed to reach necessary specialty care, the transferring physician should document that potential benefits outweigh the potential risks of transfer. In cases in which transfer is not medically necessary, documentation regarding the reason for transfer and certification that the patient is stable for transfer should also be required. A copy of this certification should accompany relevant medical records upon transfer. Absence of certification should be deemed to indicate that the transferring physician considered the patient stable for transfer.
4. The requirement that "appropriate medical records must be provided" should be clarified to state that such records must accompany the patient in transfer. Otherwise, records submitted days or even weeks later may be argued to meet the statutory requirements of COBRA, even though such delayed exchange of medical information would be practically useless in the management of an emergency room patient.
5. Given the limitations inherent to telephone screening, any potential liability for inadequate assessment and/or complications during transport should rest entirely with the transferring physician and hospital. No other party is in a position to objectively and independently assess appropriateness of transfer.
6. Once a hospital with adequate facilities receives a patient and identifies that an emergency condition or active labor exists, that hospital should be considered to have a duty to provide necessary emergency care (including emergency hospitalization) unless:

   a) The patient requires emergency, specialty care not available in the transferring hospital, such that the benefits of transfer outweigh the associated risks, and/or
   b) The patient (or the patient's legal representative) requests or agrees to transfer after being adequately informed of the reason for transfer, associated benefits and risks.

In either case, informed consent should be documented in writing and a copy should accompany the patient upon transfer. The principle of informed consent is an integral part of American health care and is normally required before a patient can be subjected to the hazards of invasive treatment (eg. surgery) and other major procedures. Given the potential hazards and associated costs of emergency transfer, informed consent should be required in these cases as well. In obvious emergency situations where expeditious transfer to a higher level of care is deemed necessary (eg. a victim of major trauma) and the patient is a minor or incompetent to consent, informed consent should be obtained from a legally responsible third party. If no such individual is readily available, transfer can be accomplished based on the principle of implied consent, in much the same way an unconscious patient can be rushed to emergency surgery to save life or limb.

By incorporating the principle of informed consent into transfer regulations based on COBRA, HCFA can dramatically strengthen the overall effectiveness of these rules. It can be expected that many private hospitals and for-profit health care corporations will object to a requirement for informed consent, arguing that it will delay or hamper medically necessary emergency transfers. Informed consent should pose no more barrier to emergency transfer than it currently does to emergency surgery. The principle of implied consent in emergency situations will be adequate for cases involving time critical transfer to life-saving tertiary care.

H) Enforcement of COBRA should not be limited to investigation of patient or hospital complaints. Most patients placed at risk by dumping are unaware of the true circumstances of their transfer or are unwilling to file a complaint against a hospital. Most public hospital administrators are extremely reluctant to request a federal investigation of what is often perceived as a local problem. City-wide hospital relations must continue to function long after a complaint is investigated and many will be reluctant to risk long-term relations for a short-term problem.

Patients and/or hospital complaints, if and when received, should not be simply referred back to the state level. Most state hospital associations are extremely powerful and many regulatory boards are defined by statute to contain a majority of members from the very industry that is being regulated. Objective review under these circumstances will be extremely difficult.

We recommend that hospitals be required to document all cases of interhospital transfer, (whether sent or received). Files should include copies of certification of stability for transfer and the reasons(s) for transfer and a copy of each patient's written consent. Adequate identifying information should also be retained to allow the complete medical record to be retrieved for review.

These files should be audited periodically (particularly in metropolitan public hospitals) to detect potential cases of 'dumping'. Suspicious cases can then be followed up with both the receiving and the transferring hospital.

This mechanism, while cumbersome, will be far more effective for detecting and regulating dumping than a system which relies on investigation of complaints. Clear documentation of transfer practices and transfer records should also be examined more carefully during periodic visits by the Joint Commission on Accreditation of Hospitals. We believe patient dumping will not cease until transferring hospitals perceive that treating a poor patient is preferable to the financial and regulatory risks of an inappropriate transfer.

CONCLUSION

The poor and uninsured patients of Tennessee and the nation need protection from medically unnecessary and potentially dangerous transfers for primarily economic reasons. Transfer of unstable patients due to inability to pay has increased despite the fact that this practice is contrary to the transfer guidelines of the American College of Surgeons, the American College of Emergency Physicians, the American Hospital Association and the Joint Commission on Accreditation of Hospitals. Adverse public opinion, voluntary restraints, generally worded legislation and local complaints have proven largely ineffective for dealing with the problem of "dumping".

In recent years, many have come to view American health care as an "industry" rather than a force for social good. Competition, profit margins, "product line management" and promise of reimbursement are rapidly replacing the sense of mission that once characterized the best ideals of medical care in this country. Faced with the need to compete to survive, many private hospitals now consider charity health care to be little more than a 'bad business practice'. Under these circumstances, it becomes easier to place an institution's economic self-interests above the best interests of an individual patient. Physicians have not proven to be immune to these pressures and many now refuse to admit a patient to the hospital without adequate promise of payment.

Lost in this process has been the implicit social contract that once characterized the relationship between hospital, physicians and the public. Short of a fundamental reordering of fiscal and social priorities in the United States, it seems likely that competitive pressures on private hospitals and physicians will increase. In this increasingly hostile environment, carefully worded regulations backed up by clear, consistent enforcement appears to be our only hope for safeguarding the welfare of patients at risk for "dumping". Many private hospital administrators regret that anti-dumping regulations are being implemented. Those of us who work for public hospitals regret that they are necessary.

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Mr. **Weiss**. Thank you, Dr. Kellermann.
Dr. Ansell.

STATEMENT OF DR. DAVID ANSELL, ATTENDING PHYSICIAN, DIVISION OF GENERAL MEDICINE/PRIMARY CARE, COOK COUNTY HOSPITAL, CHICAGO, IL

Dr. **Ansell**. It is hard to follow Dr. Relman and Dr. Kellerman, and much of what I am going to say will echo and amplify their comments.

Mr. **Weiss**. Your entire prepared statement will be entered in the record, without objection, so you may just highlight those points which you think are the most important.

Dr. **Ansell**. Just to introduce myself, I am an attending physician at Cook County Hospital in Chicago, IL, which is a public hospital. I have been there for 9 years. I am also an assistant professor of community health sciences at the Public Health School at the University of Illinois in Chicago.

I want to preface my statements by saying that what I am going to say here today is based on my research and experience in this area and does not necessarily reflect the opinions of my institutions.

First of all, I want to thank everyone for inviting me here today. I want to give a little background so you can understand the national perspective of this.

During the past 6 years, there have been dramatic increases in patient dumping reported throughout the United States. This chart just represents Cook County Hospital, which has seen over a threefold increase between 1980 and 1986. We have a blip there in 1983 and 1984 that I will explain if people are interested in the question-and-answer period.

[The chart follows:]

Patients Transferred to Cook County Hospital, 1980–86

1980	1,295
1981	2,906
1982	4,638
1983	6,769
1984	5,652
1985	4,228
1986	4,273

Dr. **Ansell**. But this increase has been reported in other places around the country. Dallas' Parkland Hospital has experienced a twofold increase. D.C. General Hospital, here in Washington, has had a sixfold increase.

To put this number in perspective in Chicago, Cook County Hospital gets transferred to its door more patients than most Chicago area hospitals admit during the year.

This is a problem, as I mentioned, of national scope. There are an estimated quarter of a million patients a year who get transferred for economic reasons.

I define patient dumping as denial or limitation in the provision of medical services for economic reasons, and the referral of that patient elsewhere. That is a broad definition.

I will be focusing here just on the economic transfer of patients, specifically in need of emergency hospitalization.

I will first outline the reasons for this increase in patient dumping and I will then describe the results of a study that my colleagues and I performed in Chicago. I just want to say that we did the study because we heard anecdotes, and we all experienced anecdotes, and we wanted to follow a number of these patients and see what happened to them.

Just a little of the background, and I will be very brief. To understand the background of this increase in patient dumping, one has to look at the broader issue of access to health care in the United States. It has been mentioned three or four times today, there are about 35 to 40 million individuals in this country, up from 25 million in 1977.

In Chicago, there are 600,000 uninsured, or one in five citizens in the city of Chicago has no health insurance.

Obviously, the implications, when a patient like this gets sick, are enormous, both for the individual patients and for the institutions.

In 1982, 1.4 million families in this country, or 5 million individuals were denied medical care for economic reasons, and there is every reason to believe that that number is greater now.

Over the same period of time as has been discussed here, reimbursement practices have changed for hospitals, leading many hospitals to establish restricted admission policies for the uninsured. Just as an example, in Chicago recently, the University of Illinois Hospital, a State-run, public hospital, has adopted a policy such as this.

There has been concern raised in many quarters that these economic considerations, and some refer to this as the wallet-biopsy, is the major determinant and takes precedence over medical reasons as a determinant of hospital transfer policy.

I think that has been said by the other panelists here.

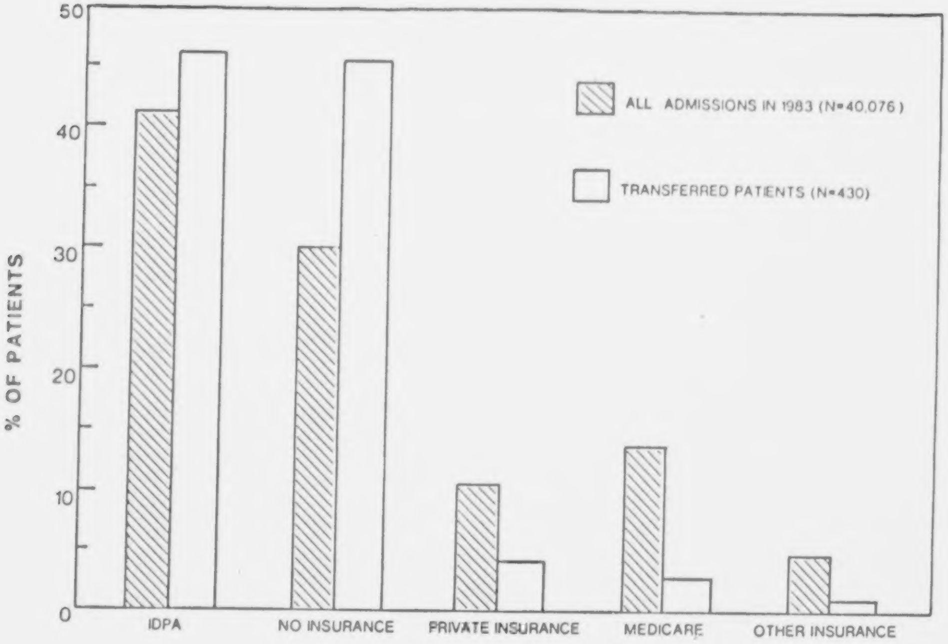
Let me just briefly review the study that we did in Chicago. We did this in late 1983. We interviewed and reviewed the charts of 500 consecutively transferred patients who were admitted to the medical and surgical services. We didn't look at obstetric patients; we didn't look at pediatric patients; and so it is limited in that way.

Patients transferred were predominantly black and Hispanic, and this is a finding that has been shown in other studies, that dumping predominantly affects minority patients.

Only 11 percent of these patients were employed full time; a small proportion had part-time work.

The next chart shows the insurance status of these patients, as compared to all patients who come to Cook County Hospital. You have to understand that patients who come to Cook County Hospital are largely the medically indigent.

[The chart follows:]



INSURANCE STATUS OF PATIENTS TRANSFERRED TO COOK COUNTY HOSPITAL

Dr. **Ansell**. We found that about half of our patients had no insurance and half had limited form of public aid, and they were more likely to be uninsured than the rest of the Cook County Hospital population. Thirty-five percent of these patients were transferred from teaching hospitals, and the reasons given for transfer was no insurance for 87 percent of these patients.

The medical implications of patient dumping are serious and sometimes shocking, as has been recorded here today. Almost a quarter of our patients ended up in an intensive care unit after admission. Twenty-four percent were unstable at the time of transfer.

Patients with medical conditions who were transferred to Cook County Hospital had a mortality rate about three times that of nontransferred medical patients to Cook County Hospital. Almost 1 out of 10 medical patients transferred to Cook County Hospital died.

I would describe just some of the patients; they are attached to the testimony. Patient No. 3 was a 36-year-old man with a stroke and dangerously elevated blood pressure. Patient No. 10 had a gunshot wound to the neck, was bleeding profusely from the major artery going to the brain. Patient No. 290 fell from a third-story window. Patient No. 584 was a 40-year-old woman with meningitis. Patient No. 587 was a 49-year-old woman with heart failure, difficulty breathing and dangerously high blood pressure.

We felt that these 106 patients were unstable, and every day patients similar to this are being transferred for economic reasons—not just in Chicago, but all around the country.

A followup study was done to our study in April 1985, which showed similar results, both in terms of patient stability and the proportion of patients transferred because of no insurance.

Just to tell you how this was done, the transfer was initiated by a phone call from the transferring hospital. We have a system in Chicago that purportedly guides this transfer process. The reason for transfer was that which was given to the Cook County Hospital physician over the phone from the transferring hospital.

In 87 percent in both studies in 1983 and in 1985, the reason for transfer was no insurance. This is a widespread, national problem.

The clinical implications of patient dumping, I want to just go over a little bit. These are the key issues and speak to what I think are the weaknesses of the Federal law.

Patients in need of emergency hospitalization are often in an unstable condition. For many conditions, stabilization can only occur after definitive surgery has occurred, or after days of intensive medical treatment. Patient stability cannot be easily predicted or guaranteed during transfer to another hospital.

All transfer carries some risk, and when a patient is emergently ill, the risk sometimes is difficult to measure. Remember these are patients whose conditions warrant emergency hospitalization. These are not elective admissions; they are seriously ill patients whose medical conditions can change from moment to moment. Even among the patients that we considered stable in our study, 15 percent required admission to an intensive care unit after admission to Cook County Hospital.

This demonstrates the degree of error that exists in instability rating. This convinces us that to transfer a patient from one hospital to another can only be justified when that transfer is made to provide services not available at the transferring hospital. That is echoing I think what Dr. Kellermann and Dr. Relman said.

Treatment delay is another factor that needs to be understood. I think this is where the communication between physicians and lawmakers has to be clear.

The decision not to admit an emergently ill patient for economic reasons will delay that patient's treatment beyond that which it would normally have been delayed. In our study, the delay in treatment due to this transfer process ranged from 1 to 18 hours, and averaged over 5 hours.

For some patients, delay in treatment may lead to premature death. This has been shown for a number of different disorders. A study of patients with severe head trauma at Cook County Hospital found that those transferred from other hospitals had a higher mortality rate than those directly admitted.

This differential in mortality was attributed to treatment delay. Again, the risk that this treatment delay may carry for an individual patient is only acceptable when that transfer is made to provide care not available at the transferring hospital.

In this situation, the transfers should be made to the closest hospital that has the facilities that can appropriately treat this patient. In our study, the overwhelming majority of patients had emergency conditions that could be treated at a presenting hospital.

Another issue that has been touched upon today is the ethics of this whole business. We looked at this in our study, specifically the issue of informed consent for transfer, which is not only an expectation in medical practice, but is a basis for lawsuits in multiple areas of medicine.

It is established practice for physicians to obtain informed consent prior to any intervention that may pose risk to a patient. In our study, only 6 percent of the patients had signed consent for transfer. Transfer for economic reasons provides no obvious benefit for a patient, and because the risks for transfer are often unpredictable, a physician faced with the situation of having to provide informed consent to a patient being transferred for economic reasons, is faced with an ethical dilemma.

We found in our study the practice was to tell the patient the reason for transfer was one reason, while telling the Cook County Hospital physician, the reason was no insurance. One hospital here in Washington, DC, has had the practice of giving the patient an option of signing a consent for transfer, or signing out of the emergency room against medical advice.

In Texas, in their State law, and I have read this carefully—I found this interesting—has faced this ethical dilemma by stipulating in this antidumping law that obtaining patient consent for economic transfers is not necessary, thus letting the hospitals off the hook.

There are ethical guidelines published by the American College of Physicians; the patient bill of rights by the American Hospital Association stipulates that informed consent must be given for transfer, and yet it is not being done.

Let me quickly go to the deficiencies I see in the laws. As I mentioned, Chicago has had a set of local guidelines since 1977 that are supposed to guarantee patient stability and well-being in the transfer process.

Illinois and 26 other States have the law requiring hospitals to provide emergency treatment to all patients. Despite these guidelines and laws, patient dumping continues to be a problem.

There are three central deficiencies in the State and Federal antidumping laws. The first is the definition of what constitutes an emergency lacks clarity. In the case of the Federal law, the definition is too general and vague. I have some recommendations afterwards that I could give.

Second, all patient dumping laws provide for the patient being transferred as being stabilized, and as mentioned before, that is not something that is necessarily predictable, and is not necessarily even desirable for a patient to be stabilized. It is an elusive concept; there is going to be disagreement among physicians, and patients' conditions are such that it is often unpredictable to define stability.

So, the requirement of stability is going to render the law unenforceable.

The third weakness of the current Federal law is the question of monitoring and enforcement. I think they have been raised pretty extensively here today, and I won't belabor it. I will just add a little bit to that by asking how will we keep track of these patients, how will patients be informed of the law? You know, these patients who don't have access to medical services, often don't have access to legal services, also.

How will determinations of violations be made? I am of the firm opinion because of the vague definition of emergency, the unrealistic expectation of stabilization, that the Federal antidumping legislation will not be effective and the dumping of emergency patients will continue.

The only way to protect all emergency patients from the potential ill effects of patient dumping is to prohibit the practice of transferring any patients in need of emergency care for economic reasons. Transfer of emergency patients from one hospital to another should only be allowed when the transfer is motivated to provide medical services not available at the transferring hospital.

A permanent solution to the problem of patient dumping will occur only, as others have said, when the larger issue of health care financing, both for the individuals and the hospitals is addressed. I applaud the recognition that Congress has begun to give to this problem, and urge that in addition to legislative initiatives, that you begin to develop a national health program, such that all sick people are guaranteed equal access to our medical care system, regardless of ability to pay.

Just for the additions to the law, I would support Dr. Relman's suggestion about a written physician's form for every transfer, and that the transfer only be for medically justifiable reasons, and I would support Dr. Kellermann's suggestion that informed consent be required.

I think when we start requiring hospitals to give informed consent, we will find more appropriate triage of these patients.

[The prepared statement of Dr. Ansell follows:]

TESTIMONY

DAVID ANSELL, M.D.

Attending Physician
Department of Medicine
Cook County Hospital
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I want to thank the chairman and members of the committee for inviting me here today.

During the past six years there have been dramatic increases in patient dumping throughout the United States. Between 1980 and 1986 there was a 3 fold increase in transfers to Cook County Hospital in Chicago, Illinois; Dallas' Parkland Hospital experienced a 2 fold increase; D. C. General Hospital experienced a 6 fold increase. To put this in perspective, Cook County Hospital gets transferred to its door more patients than most Chicago area hospitals admit during a year. This is a problem of national scope. There are an estimated 250,000 emergency patients each year who get transferred for economic reasons.

I define patient dumping as the denial or limitation in the provision of medical services for economic reasons and the referral of that patient elsewhere. I will be focusing specifically on the economic transfer of patients in need of emergency hospitalization.

I will first outline the reasons for this increase in dumping. I will then describe the results from the study that my colleagues and I performed in Chicago. Finally, I will comment on proposed solutions for the problem with particular reference to the Federal law designed to stop dumping.

To understand why dumping has increased, one has to look at the issue of access to health care in the U.S. of which the dumping of emergency patients is but one manifestation. There are between 35 and 40 million uninsured individuals in the United States up from 25 million in 1977. In Chicago for example 600,000 people or one out of every five individuals has no health insurance coverage.

In 1982 1.4 million families in the United State (5 million people) were denied medical care for economic reasons. This includes emergency and non-emergency care. There is reason to believe that this number is ever greater now.

Over the same period of time, changes in reimbursement practices for hospitals have caused many hospitals to adopt policies restricting admission for the uninsured. Recently, for example, in Chicago, the University of Illinois Hospital, the state run public hospital adopted such a policy.

There has been concern raised in many quarters that these economic considerations-some refer to this as the "wallet biopsy" -takes precedent over patient well-being as a major determinant of hospital transfer policy.

I would like to briefly review the study my colleagues and I performed at Cook County Hospital in Chicago in 1983. We interviewed and reviewed the charts of 500 patients who were transferred to Cook County Hospital from other hospital emergency rooms and required admission. Then we compared these patients to patients at Cook County Hospital who were not transferred.

Patients transferred were predominately black and Hispanic males. That the practice of dumping disproportionately affects minorities has been demonstrated in other studies also.

Only 11% of these patients were employed full-time. About half (46%) had no insurance and half (46%) were recipients of limited aid from the Illinois Department of Public Aid. Compared to all patients who get admitted to Cook County Hospital these patients were significantly less likely to be insured. These patients were transferred from all types of hospitals. Thirty-five percent were transferred from teaching hospitals. The reason given for transfer was "no insurance" for 87% of the patients.

The medical implications of patient dumping are serious and sometimes shocking. Almost one quarter of the patients were admitted to an Intensive Care Unit. In addition 24% were unstable at the time of transfer. Patients with medical conditions who were transferred had a mortality rate almost three times that of non-transferred medical patients at Cook County Hospital; almost one out of every ten medical transfers died.

I would like to describe some of the patients. Included for your review is a list of the clinical characteristics of the 106 patients that we felt were unstable. Patient 3 was a 36 year old man with a stroke and dangerously elevated blood pressure. Patient 10 had a gunshot wound to the neck, and was bleeding profusely from the major artery going to the brain. Patient 86 was 41 year old man with gun shot wounds to his head, chest and abdomen in a coma and on a respirator. Patient 116 was an unconscious woman with suspected drug overdose. Patient 290 fell from a 3rd story window. Patient 584 was a 40 year old woman with meningitis. Case 587 was a 49 year old woman with heart failure, difficulty breathing and dangerously high blood pressure. Everyday, patients similar to this are being put at risk by economically motivated transfers.

A follow up study to our 1983 study was performed in 1984/85 and showed similar results. Studies from Oakland and Dallas have also confirmed our experience. Reports of patient dumping from rural areas suggest that this is a widespread problem.

What are the clinical implications of patient dumping? Patients in need of emergency hospitalization are often in an unstable condition. For many conditions, stabilization can only occur after definitive surgery has occurred or after days of intensive medical treatment. Patient stability can not be easily predicted or guaranteed during transfer to another hospital. Remember these are patients whose conditions warrant emergency hospitalization. These are not elective admissions. They are seriously ill patients whose medical conditions can change abruptly from moment to moment.

Even among the patients we considered "stable" in our study, 15% required admission to an intensive care unit after admission to Cook County Hospital. This demonstrates the degree of error that exists in instability rating. This convinces us that the transfer of patients from one hospital to another can only be justified when that transfer is made to provide services not available at the transferring hospital.

Treatment delay is also a factor that needs to be considered in economic transfers. The decision not to admit an emergently ill patient for economic reasons will delay that patient's treatment. In our study the delay in treatment due to this transfer process ranged from one to eighteen hours. For some patients, delay in treatment may lead to premature death. A study of patients with severe head trauma at Cook County Hospital found that those transferred from other hospitals had a higher mortality rate then those directly admitted. This differential in mortality was attributed to treatment delay.

Again, the risk that treatment delay may carry for an individual patient is only acceptable when that transfer is made to provide care not available at the transferring hospital. And in this situation, the transfer should be made to the closest hospital with the appropriate facilities. In our study the overwhelming majority of patients had emergency conditions that could be treated at the presenting hospital.

One other important factor is the issue of informed consent. It is established practice for physicians to obtain informed consent prior to any intervention that might pose risk to a patient. In our study, only 6% of patients had signed consent for transfer. Because transfer for economic reasons provide no benefits to the patient and because the risks of transfer are often unpredictable - a physician in an emergency room is forced with a ethical dilemma when transferring a patient for economic reasons. We found that in our study, the practice in many cases was to tell the patient he was being transferred for some other reason while telling the Cook County Hospital physician the reason was "no insurance."

One hospital here is Washington, D.C. has had the practice of giving the patient an "option" of signing a consent for transfer or signing out of the emergency room against medical advice.

And Texas has faced this ethical dilemma by stipulating in its anti-dumping law that obtaining patient consent for economic transfers is not necessary-thus letting transferring hospitals "off the hook."

I would like to conclude by discussing the shortcomings of existing local guidelines, state laws and specifically the federal anti-dumping law. Chicago has had a set of local guidelines since 1977 that are supposed to guarantee patient stability and well-being in the transfer process. Illinois (and 21 other states) has a law requiring hospitals to provide emergency treatment to all patients. Despite these guidelines and laws, dumping continues to be a problem.

There are three central deficiencies in state and federal "anti-dumping" laws. The first is that the definition of what constitutes an emergency lacks clarity in most laws. In the case of the federal law the definition is too general and vague.

Secondly, all patient dumping laws provide for patients to be transferred after being stabilized. As articulated a few years ago by Dr. Arnold Relman, "Stabilization of emergency cases is a notion used by hospital managers to justify transfer for economic reasons." As I mentioned before, for many emergency cases, stabilization requires days of intensive therapy and cannot necessarily be accomplished in an emergency room. Thus the requirement for prior stabilization runs counter to what is often medically possible or even desirable. Presently, there are no accurate medical protocols that allow a physician to predict for all patients who is stable and who is not. Therefore, unstable patients will continue to be transferred for economic reasons.

The third weakness of the current federal law is the question of monitoring and enforcement. The federal anti patient dumping legislation went into effect in August 1986 and to date we have not seen the proposals for monitoring and enforcement. How will the government keep track of these patients? What kind of follow up procedures will be provided? How will patients be informed? How will determinations of violations be made? I am of the firm opinion that because of the vague definition of emergency and the unrealistic expectation of prior stabilization, the federal anti dumping legislation will not be effective and the dumping of emergency patients will continue.

The only way to protect all individual emergency patients from the potential ill effects of patient dumping is to prohibit the practice of transferring any patients in need of emergency care for economic reasons. Transfer of emergency patients from one hospital to another should only be allowed when that transfer is motivated to provide medical services not available at the transferring hospital.

A permanent solution to the problem of patient dumping will occur only when the larger issue of health care financing is addressed. I applaud the recognition that Congress has begun to give the shocking and uniquely American problem of patient dumping, and urge that in addition to legislative initiatives, you begin to develop a national health program such that all sick people are guaranteed equal access to our medical care system regardless of ability to pay.

TRANSFERS TO A PUBLIC HOSPITAL
A Prospective Study of 467 Patients
Robert L. Schiff, M.D., David A. Ansell, M.D.; et al;
(N Engl J Med 1986;314: 552 - 7)

CATEGORY 1: TRAUMATIC INJURIES WITH SHOCK, BLOOD LOSS ≥ 500 CC, VITAL ORGAN DAMAGE, OR VASCULAR DAMAGE

Study #	Age/Sex	Unstable Clinical Parameter(s)
10	20/M	Gunshot wound to neck, bleeding profusely from transected external carotid artery branch, > 500 cc blood loss.
12	38/M	Stab wound to right arm with brachial artery injury, absent brachial pulse.
[illegible]8	25/M	Stab wound to left neck.
43	20/M	Open fracture of ankle with cold foot and absent pulse.
52	37/F	11% 1st and 2nd degree burns of face and chest with RR 44.
57	30/M	Blunt abdominal trauma with falling hematocrit, and syncope. Required blood transfusion before transfer.
62	62/M	Gunshot wound to both thighs, initial BP 74/48, left pedal pulse faint.
70	33/M	Multiple gunshot wounds to abdomen, BP 90/60, hematuria, and diffusely tender abdomen.
71	35/M	Partial amputation of both hands with initial BP 80/60.
85	26/M	Gunshot wounds to chest and abdomen requiring blood transfusions before transfer.
120	18/M	Stab wound to chest, hemopneumothorax, 575cc blood loss, hematocrit drop from 43% to 24%.
172	42/M	Multiple stab wounds, T 95°, BP 70/40.
213	21/M	Stab wound to chest, initial BP 90/50, 450cc blood loss.
221	29/M	Multiple stab wounds, chest tube drained 600cc blood, acidotic (arterial pH 7.30).
253	28/M	Multiple trauma with probable splenic rupture, hematuria, and drop in hematocrit from 44% to 36%.

(continued)

Table 2 (continued)

Study #	Age/Sex	Unstable Clinical Parameter(s)
384	23/M	Multiple blunt trauma, loss of consciousness, subluxation of C2 over C3 spine.
426	25/M	Pelvic and radial fractures, BP 90/50.
431	31/F	Multiple blunt trauma, multiple fractures, BP 95/0, confused.
433	19/M	Gunshot wound to chest, initial BP 70/30, 1000cc blood loss from chest.
487	55/M	Stab wound to face with swelling, dysphagia, and choking sensation.
503	50/M	Multiple trauma with flail chest, Hb 8 gm%, required 2 units packed red cells before transfer.
CATEGORY 2: NON-TRAUMATIC CAUSES OF ABNORMAL MENTAL STATUS OR ACUTE COMPLICATED CEREBROVASCULAR ACCIDENTS		
42	58/F	Chronic lymphocytic leukemia with progressive confusion and loss of vision.
73	74/M	Recent syncopal episodes, orthostatic BP change from 180/100 supine to 0 on standing.
100	54/F	Acute cerebral embolism, atrial fibrillation.
116	27/F	Unknown drug overdose, unresponsive, initial RR 36.
117	33/M	Diabetic ketoacidosis, axillary T 101°, confused.
136	41/M	Delerium tremens.
138	28/M	Delerium tremens.
161	62/M	Acute cerebrovascular accident, stuporous, BP 198/120.
211	37/M	Delerium tremens.
259	27/M	Delerium tremens, seizures, acute pancreatitis.
302	40/M	Acute cerebrovascular accident, unresponsive with decorticate posturing.
332	33/M	Delerium tremens.
376	27/M	Altered mental status (delerious) and seizures.
396	34/M	Delerium tremens.

(continued)

Table 2 (continued)

Study #	Age/Sex	Unstable Clinical Parameter(s)
479	56/M	Acute organic brain syndrome.
515	58/M	Confusion, fever, wet gangrene of foot.
523	53/M	Confusion, diabetes mellitus, with T 99.5°.
581	16/M	Multiple seizures, abnormal mental status.
609	22/M	Gunshot wound to arm with altered mental status (difficult to arouse).
CATEGORY 3: TRAUMATIC CAUSES OF ABNORMAL MENTAL STATUS AND/OR FOCAL NEUROLOGIC DEFICITS		
1	31/M	Blunt head trauma, stuporous, diagnosis subdural hematoma.
21	30/M	Multiple trauma, hematuria, right pupil constricted, left pupil dilated, initial BP 96/50.
.	46/M	Blunt head trauma with possible basilar skull fracture, was vomiting in Emergency Department.
79	40/M	Comatose, anisocoria, diagnosis subdural hematoma, intubated, given mannitol.
86	41/M	Comatose with gunshot wounds to head, chest, and abdomen. Intubated, given mannitol.
108	50/M	Delerium, T 101.8°, diagnosis possible subdural hematoma.
114	27/M	Motor vehicle accident, coma, decerebrate posturing, no spontaneous respirations, intubated, given mannitol.
163	53/M	Head trauma, stuporous, BP 300/160.
167	58/M	Head trauma, confusion, pupils reacting differently, T 93.4°.
173	24/M	Blunt head trauma with skull and multiple facial fractures, disoriented, BP 80/60, P 46.
240	38/M	Abnormal mental status, having seizures, diagnosis rule-out subdural hematoma.
290	32/M	Fell from third story, confused.

Table 2 (continued)

Study #	Age/Sex	Unstable Clinical Parameter(s)
454	57/M	Motor vehicle accident, head trauma, comatose, BP 95/73 in military antishock trousers, T 91°.
504	51/M	Multiple trauma, multiple fractures, confused.
597	43/M	Head trauma, lethargic, diplopia.
599	39/M	Skull fracture, possible subdural hematoma.
CATEGORY 4: ACUTE RESPIRATORY FAILURE OR SEVERE RESPIRATORY DISTRESS		
18	48/M	Pneumonia with hypoxia, pO_2 57, RR 26-33.
31	32/M	Acute pulmonary edema, ABG: pH 7.37, pO_2 54, pCO_2 29 on 5L O_2 by nasal cannula.
	30/F	Bronchial asthma, initial ABG: pH 7.11, pO_2 103, pCO_2 81.
83	63/F	Congestive heart failure, ABG: pH 7.24, pO_2 80, pCO_2 79, P 43-63 with pacemaker not always capturing.
165	54/M	Acute cholecystitis, right lower lobe infiltrate with hypoxia, pO_2 58 on 3L O_2.
195	29/F	Pneumonia, RR 40, P 140, ABG: pH 7.54, pO_2 51, pCO_2 20, HCO_3 17 on 4L O_2.
226	53/M	Respiratory distress, RR 32, P 112, ABG: pH 7.40, pO_2 69, pCO_2 34 on 4L O_2.
235	61/F	Congestive heart failure, respiratory distress, atrial fibrillation, pneumonia, T 95°, P 102.
238	43/M	Pneumonia, RR 36, P 120-140, ABG, pH 7.42, pO_2 67, pCO_2 30, HCO_3 19 on room air.
353	42/M	Chronic obstructive pulmonary disease with pneumothorax, ABG: pH 7.33, pO_2 59, pCO_2 43 on 2L O_2.
358	61/F	Pulmonary edema with initial ABG: pH 7.41, pO_2 73, pCO_2 14.
519	55/M	Asthma and pneumonia, initial ABG: pH 7.31, pO_2 74, pCO_2 43, HCO_3 21.
540	57/M	Pneumonia with hypoxia pO_2 56, RR 28.

Table 2 (continued)

Study #	Age/Sex	Unstable Clinical Parameter(s)
566	19/F	Asthma and pneumonia P 132, RR 32, ABG: pH 7.43, pO_2 78, pCO_2 35 on 40% O_2 by mask.
600	30/M	Pneumonia and congestive heart failure, P 110, RR 28, ABG: pH 7.55, pO_2 78, pCO_2 24, HCO_3 22 on 3L O_2.
CATEGORY 5: SEVERE ACUTE METABOLIC ABNORMALITIES		
111	59/M	Hypoglycemia with initial glucose 0 mg% by Chemstrip, after 50% glucose i.v. mental status remained abnormal.
157	26/F	Diabetic ketoacidosis, T 95.4°, ABG: pH 7.26, pO_2 106, pCO_2 26, HCO_3 11, WBC 17,000/mm3.
[illegible]	55/F	Hypoglycemia, delerium, initial glucose 9 mg%.
373	42/F	Ascites, hyponatremia (serum Na 112 meq/L), hypoxia, ABG: pH 7.51, pO_2 76, pCO_2 22, WBC 13,700/mm^3.
410	40/M	Hypoglycemia, glucose 2 mg%.
448	40/M	Diabetic ketoacidosis, ABG: pH 7.25, pO_2 130, pCO_2 23, HCO_3 10, P 140, BP 90/60.
481	53/M	Diabetic ketoacidosis, ABG: pH 7.28, pO_2 85, pCO_2 29, HCO_3 14.
537	50/M	Pancreatitis with metabolic acidosis, ABG: pH 7.34, pO_2 123, pCO_2 26, HCO_3 14.
541	56/M	Metabolic acidosis with initial ABG: pH 7.12, pO_2 140, pCO_2 30, HCO_3 10.
CATEGORY 6: SEVERE ANEMIA OR ACUTE INTERNAL BLEEDING		
88	44/M	Upper GI bleed, Jehovah's Witness, refusing blood transfusion, hematocrit 24%, P 144.
90	74/M	Gross hematuria, hematocrit 23%, T 95.8°.
236	33/M	Coombs positive hemolytic anemia, hematocrit 10%, BP 100/50.

Study #	Age/Sex	Unstable Clinical Parameter(s)
343	34/F	Right lower lobe pneumonia, vaginal bleed, hematocrit 21%.
424	53/F	Upper GI bleed, BP 90/70 initially, hematocrit 17%, stuporous, metabolic acidosis (HCO_3 17).
462	30/M	Upper GI bleed, hematocrit 23%, required i.v. vasopressin and 2 units packed cells before transfer.
560	58M	Upper GI bleed, BP 90/64, T 95.9°, hematocrit 29%.
576	37/M	Hemoptysis of 700cc, Hb 11.5 gm%.
CATEGORY 7: SERIOUS ACUTE INFECTIONS		
	1/F	Rectal bleeding, hematocrit 27%, T 104°, ABG: pH 7.53, pO_2 67, pCO_2 29, HCO_3 24 on room air, WBC 19,000/mm^3.
58	21/M	Diabetes mellitus with pneumonia, RR 32, T 102.3°, WBC 26,500/mm^3.
368	21/M	Diabetes mellitus with T 101°, possible septic shoulder, WBC 28,500/mm^3.
406	53/M	Lung cancer, T 95°, RR 32, BP 90/70, ABG: pH 7.42, pO_2 63, pCO_2 32 on 3L O_2.
432	29/M	Hepatitis with coagulopathy and GI bleed, hematocrit 30%, T 100.5°, BP 106/50, WBC 17,000/mm^3.
584	40/F	Meningitis, WBC 13,700/mm^3, T 103°.
CATEGORY 8: SEVERE HYPERTENSIVE CONDITIONS		
3	36/M	Acute cerebrovascular accident, initial BP 230/130.
142	26/M	Hypertension with initial BP 212/150, over-medicated, BP dropped to 102/90 25 minutes later.
225	36/M	Hypertension with epistaxis, initial BP 240/170.
587	49/F	Hypertension and congestive heart failure, BP 240/180, ABG: pH 7.35, pO_2 59, pCO_2 30.

Study #	Age/Sex	Unstable Clinical Parameter(s)
CATEGORY 9:		ACUTE ABDOMINAL CONDITIONS WITH SIGNS OF PERITONITIS OR PERFORATION
322	26/M	Stab wound to abdomen, BP 100/40, peritoneal signs present.
539	24/M	Acute abdomen with free air under diaphragm on x-ray.
550	23/M	Small bowel obstruction with peritonitis.
568	22/M	Perforated peptic ulcer with peritonitis.
CATEGORY 10:		NON-HEMORRHAGIC CAUSES OF SHOCK
	26/M	Nausea, vomiting, diarrhea, initial vital signs: BP 50 palpable, T 95°, P 140, RR 28.
192	59/M	Pneumonia, BP 92/64, WBC 30,000/mm^3.
220	53/F	Cancer of mouth, BP 93/65, WBC 20,000/mm^3.

Conventions and Abbreviations:

ABG	Arterial blood gas expressed as partial pressure in mm Hg.
BP	Blood pressure expressed in mm Hg.
GI	Gastrointestinal.
HCO_3	Bicarbonate expressed in mEq/l.
P	Pulse.
RR	Respiratory rate.
T	Temperature expressed in degrees Fahrenheit.
WBC	White blood count.

SPECIAL ARTICLE

TRANSFERS TO A PUBLIC HOSPITAL

A Prospective Study of 467 Patients

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Abstract In recent years there has been a dramatic increase in the number of patients transferred to public hospitals in the United States. We prospectively studied 467 medical and surgical patients who were transferred from the emergency departments of other hospitals in the Chicago area to Cook County Hospital and subsequently admitted.

Eighty-nine percent of the transferred patients were black or Hispanic, and 81 percent were unemployed. Most (87 percent) were transferred because they lacked adequate medical insurance. Only 6 percent of the patients had given written informed consent for transfer. Twenty-two percent required admission to an intensive care unit, usually within 24 hours of arrival. Twenty-four percent were in an unstable clinical condition at the transferring hospital. The proportion of transferred medical-service patients who died was 9.4 percent, which was significantly higher than the proportion of medical-service patients who were not transferred (3.8 percent, $P<0.01$). There was no significant difference in the proportion of deaths on the surgical service between patients who were transferred and those who were not (1.5 vs. 2.4 percent).

We conclude that patients are transferred to public hospitals predominantly for economic reasons, in spite of the fact that many of them are in an unstable condition at the time of transfer. (N Engl J Med 1986; 314:552-7.)

THE transfer of patients from one hospital to another is a widespread practice throughout the United States. Transfer is considered appropriate when there is a need for specialty or tertiary care that is unavailable at the transferring hospital.[1,2] Inability to pay for hospital services is also regarded by some as an acceptable reason for the transfer of patients from private to public hospitals. This has been a longstanding practice in such cities as Chicago, Oakland, Los Angeles, Dallas, Atlanta, and Washington, D.C.[3-9]

In recent years there have been increases in the number of interhospital transfers of patients to public general hospitals across the United States. In Washington, D.C., for example, transfers from private hospitals to District of Columbia General Hospital rose from 169 to nearly 1000 annually[8] between the years 1981 and 1984; similar increases have been noted in other cities.[10] At Cook County Hospital in Chicago, the number of interhospital transfers has risen steadily from 1295 in 1980 to 2906 in 1981, 4368 in 1982, and 6769 in 1983.

These increases in the numbers of transfers have occurred during a period of cutbacks in federal and state health care funding for the poor. Some have expressed concern that economic considerations may take precedence over patient well-being as a major determinant of hospital transfer policy.[4,11,12] There have also been reports that delays in treatment may be harmful to some patients.[13-15] Interhospital transfers for economic reasons cause such delays and may therefore have detrimental consequences for patients in some cases.

This report describes a prospective study of patients transferred to a public general hospital. Five hundred patients consecutively transferred to Cook County Hospital from other hospital emergency departments in the Chicago area formed the study sample. We present a demographic profile of the transferred patients and report the reason for patient transfer, whether there was admission to the intensive care unit, the length of hospital stay, patient charges, and outcome. In addition, we evaluate the stability of the patient's condition at the time of transfer and examine various aspects of the transfer process, including treatment delay caused by transfer and the informed-consent procedure. Finally, we report the costs incurred by Cook County Hospital as a result of these transfers.

METHODS

The study was conducted at Cook County Hospital, Chicago's only public general hospital, which had 1342 beds, 40,076 admissions, and 242,000 emergency-department visits in 1983. Data were collected on 500 consecutive adult patients who were transferred from another hospital's emergency department to Cook County Hospital from November 20, 1983, to January 1, 1984, and subsequently admitted to the medical or surgical services. Excluded from this study were patients admitted to the obstetrical, gynecologic, or pediatric services.

The transfer process was initiated by a phone call from the transferring hospital to our emergency department. During this call, a medical or surgical resident filled out a transfer form with the name of the patient and the transferring hospital, vital signs, a brief clinical summary, and the reason for the requested transfer. The resident either accepted or rejected the transfer request. During the study period, 93 percent of the requests for transfer were accepted. Reasons for refusal included that hospitalization was not indicated, that the patient's condition was not sufficiently stable to permit transfer (most frequently because of possible myocardial infarction), and that there was noncompliance with transfer protocols. Neither the physicians at the transferring hospitals nor those at the Cook County Hospital were aware that this study was being conducted.

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During the study period, 602 adult medical and surgical patients were transferred from other hospitals to our emergency department, and 500 were admitted. Detailed review of the hospital records identified 16 patients who did not meet our study criteria and were therefore excluded: eight because they were inpatient transfers, and eight because they were not transfers to the medical or surgical service. Inpatient charts were located for 467 of the 484 patients (96 percent). These 467 patients constituted the study population.

Each patient was identified prospectively by daily review of the Cook County Hospital emergency-department records, transfer forms, hospital admission records, and trauma-unit admission book. Patient interviews were conducted by one of the four investigating physicians (D.A., A.I., R.S., or J.S.) or a fourth-year medical student (A.M.), usually within the first 24 hours of admission. The interview involved questions about employment, insurance status, and whether the patient had been informed of the transfer and had given consent. After discharge, data were abstracted from the transfer form, the transferring hospital's emergency-department record (photocopies of which were usually sent with the patients), the Cook County Hospital's emergency-department record, and the inpatient chart. Items that were abstracted included basic demographic data, vital signs, laboratory data, and the times and dates of all major hospital emergency-department and ward admissions and discharges of the patients. The physician investigators were not involved in the care of the study patients.

The assessment of the stability of the patient's condition was based on review of the clinical information available in the records of the transferring hospital. All patients whose condition was classified as unstable had clear evidence of at least one of the following conditions at the transferring hospital: shock (systolic blood pressure <100 mm Hg in a patient with the clinical signs of shock); acute cardiac or respiratory insufficiency (arterial partial pressure of oxygen <60 mm Hg, respiratory acidosis, or evidence of severe respiratory distress); severe acute metabolic abnormalities (diabetic ketoacidosis or other unexplained causes of metabolic acidosis, hypoglycemia, or severe hyponatremia); abnormal mental status or focal neurologic deficits caused by trauma, abnormal mental status or acute complicated cerebrovascular accidents of nontraumatic origin; severe anemia or active internal bleeding (with evidence of a dropping hematocrit or hematocrit <25 percent, shock, or blood loss ≥500 ml); severe traumatic injuries (with evidence of shock, blood loss ≥500 ml, a low or dropping hematocrit, vital-organ or vascular injury, unstable spinal fractures, flail chest, or severe facial burns); acute abdominal conditions with signs of peritonitis or perforation; severe hypertension (blood pressure ≥200/130 mm Hg, with signs of end-organ damage); or potentially life-threatening infections (including meningitis, suspected sepsis, or complicated infections in diabetic patients or other compromised hosts).

All data from the transferring hospital were reviewed by one of the four investigating physicians to determine stability status. The patients whose condition was thought to be unstable were then presented to the three other project physicians. For any patient's condition to be classified as unstable, the other three investigators had to concur after reviewing the pertinent clinical data. If even one physician did not concur, the patient was classified as stable. Patients with surgical diagnoses whose condition was thought to be unstable were reviewed secondarily by a board-certified general surgeon. Surgical patients were considered in an unstable condition only if all five clinicians agreed.

Treatment delay was defined as the time that elapsed from the transfer-request phone call to Cook County Hospital until the time the patient was discharged from the Cook County Hospital emergency department. The phone call marked the point at which the physician at the transferring hospital decided that the patient should be transferred to Cook County Hospital. The discharge time from our emergency department represented the point at which the patient was actually admitted to the hospital for definitive treatment. Activities during the interval between these two events included calling for the ambulance, transportation of the patient to and from the ambulance, the ambulance ride, registration and reexamination at Cook County Hospital, and repeat or additional roentgenographic or laboratory tests if needed. This elapsed time constituted the additional delay in treatment caused by the transfer process.

The data were abstracted by the investigating physicians, entered on specially prepared and pretested code sheets, and then entered into a Control Data Corporation Cyber 170/730 system at Northwestern University under the supervision of one of us who is the project epidemiologist (S.W.). Five percent of the charts were randomly selected and recoded to examine the accuracy of the abstracting process. There was a 92 percent rate of exact agreement between the recoded and originally coded items. All data went through three separate editing programs designed to ensure accuracy and consistency. All data items were not always available for each patient, and percentages were therefore based on the number of patients in each category for whom data were available.

Statistical tests have been computed as chi-square with 1 degree of freedom (corrected for continuity) unless otherwise specified.

RESULTS

Demographic Data

Forty-two hospitals transferred the 467 patients, sending between 1 and 36 each (median, 6). The average age of these patients was 36 years, and 78 percent were male. Seventy-seven percent were black, 12 percent Hispanic, 10 percent white, and 1 percent of other ethnic or racial origin. Eighty-one percent of the patients were unemployed, 11 percent worked full time, and 8 percent worked part time.

An evaluation of the medical-insurance status of 430 of the patients showed that 46 percent were recipients of aid from the Illinois Department of Public Aid (this includes Medicaid), 46 percent had no insurance, 4 percent had private insurance, 3 percent had Medicare, and 1 percent had other, miscellaneous coverage. In comparison, 30 percent of all the 40,076 persons admitted to Cook County Hospital in 1983 had no health insurance coverage ($P<0.0001$, Fig. 1). Nationally, only 8.2 percent of patients in short-term general hospitals have no insurance.[19]

The reason for transfer given to the Cook County Hospital resident in the transfer-request phone call was lack of insurance for 87 percent of the 245 patients for whom this information was available. The need for tertiary or specialty care was given as the reason for transfer in 4 percent of the cases, a lack of beds at the transferring hospital in 3 percent, the patient's request in 1 percent, and other reasons in 5 percent.

Resource Use and Patient Outcome

Seventy-three percent of the patients were admitted to the surgical service, and 27 percent to the medical service. Of those admitted to the surgical service, the majority were admitted to the trauma (53 percent), orthopedic (20 percent), general surgical (12 percent), or neurosurgical services (4 percent). Eleven percent were admitted to other surgical services. Twenty-two percent (104) of the study patients were admitted to an intensive care unit during their hospitalization, most of these (88 percent) within the first 24 hours. The average length of hospital stay for the study patients was 9½ days.

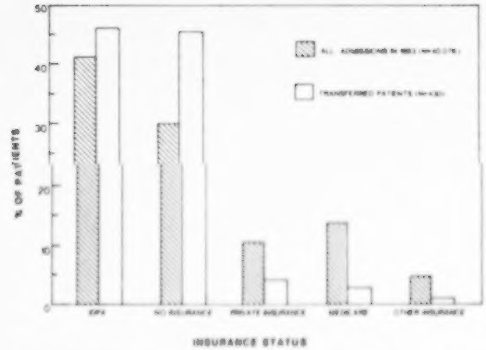

Figure 1. Distribution According to Medical-Insurance Status of Transferred Patients and All Patients Admitted to Cook County Hospital in 1983.

The distributions of the two groups are significantly different (chi-square)(4) = 101.52, P<0.0001), as are the proportions in each insurance category considered separately (Illinois Department of Public Aid (IDPA), P<0.05; no insurance, private insurance, and Medicare, P<0.0001; and other insurance, P<0.001).

Cook County Hospital uses an all-inclusive daily rate for all patient charges (e.g., room, board, physicians, laboratory, and ancillary services and supplies) of $630 per day for patients on the wards and $1500 per day for patients in the intensive care unit. The total charges for the transferred patients, based on the actual number of their intensive care and ward days, amounted to $3.35 million.

We also evaluated patient outcome. Seventeen (3.6 percent) of the study patients died during the hospitalization. An additional 18 (3.9 percent) were discharged to a chronic care facility. The proportion of transferred patients admitted to the medical service who died was 9.4 percent (12 of 128), whereas the proportion of non-transferred medical-service patients admitted to Cook County Hospital during the study period who died was 3.8 percent (43 of 1120) (P<0.01). The proportion of transferred surgical patients who died was 1.5 percent (5 of 339), which is not significantly different from the proportion of non-transferred surgical patients (2.4 percent, 28 of 1149) admitted during the study period (P>0.10, Table 1).

Instability and Treatment Delay

We made a clinical assessment of the stability of the patients' condition based on the transferring hospitals' records. Of the 467 charts reviewed, 435 (93 percent) had sufficient information to make a determination of stability. Of these, 106 patients (24 percent) were classified as being in an unstable condition. Table 2 lists 20 randomly selected patients who were in an unstable condition, with their key clinical features.* In some patients, treatment was initiated before transfer, but definitive treatment was usually not begun. Examples of definitive measures not begun include emergency surgical procedures (e.g., exploratory surgery, repair of vessels or vital organs or both, and craniotomies), antibiotic therapy, and emergency invasive diagnostic tests.

The fatality ratio was 7.5 percent (8 of 106) among the patients in unstable condition and 1.5 percent (5 of 329) among those in stable condition (P<0.005). Nearly 39 percent of the unstable patients (41 of 106) were admitted to an intensive care unit, as compared with 14.6 percent (48 of 329) of the stable patients (P<0.001, Table 1).

Transfer Process

The transfer process resulted in an average treatment delay of 5.1 hours (range, 1 to 18 hours; median, 4.6) after the need for hospitalization had been determined at the transferring hospital. A signed informed consent for transfer was present in only 25 (6 percent) of the 437 transferring-hospital records that were available for review; 21 of these were from a single hospital. Thirteen percent of the patients we interviewed reported that they were not informed in advance of their impending transfer to Cook County Hospital. Of those informed of transfer, 36 percent reported that they were not told why they were being transferred.

When the reason for transfer was known by the patient, it was frequently different from the reason given to the resident at Cook County Hospital during the transfer-request phone call. For example, when "no insurance" was the reason reported for transfer, there was a discrepancy between the frequency with which this reason was given during the requesting phone call (87 percent) and the frequency with which it was reported by the patients (64 percent) (P<0.001).

Thirty-four percent of all patients were transferred from teaching hospitals. Thirty-five percent of the patients in an unstable condition were transferred from teaching hospitals. For 99 percent of the unstable patients transferred from nonteaching hospitals, there

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*See NAPS document no. 04174 for seven pages of supplementary material on all 106 patients in an unstable condition. Order from NAPS c/o Microfiche Publications, P.O. Box 3513, Grand Central Station, New York, NY 10163. Remit in advance (in U.S. funds only) $7.75 for photocopies or $4 for microfiche. Outside the U.S. and Canada add postage of $4.50 ($1.50 for microfiche postage).

Table 1. The Proportion of Transferred Patients Admitted to an Intensive Care Unit (ICU) and the Proportion Who Died, According to Service and Stability Rating

Patient Category	No. of Patients	Admitted to an ICU	Died
		percent	
All patients	467	22.3	3.6
Medical	128	14.8	9.4
Surgical	339	25.1	1.5
Stable	329	14.6	1.5
Medical	62	6.5	3.2
Surgical	267	16.5	1.1
Unstable	106	38.7	7.5
Medical	55	18.2	10.9
Surgical	51	60.8	3.9

was a closer teaching hospital than Cook County Hospital.

Discussion

Reductions in federal and state funding for medical care began in earnest in 1980. Since that time, damage to the financial integrity of public hospitals and to the well-being of patients has been predicted and reported.[17-20] The marked increase in the number of patient transfers to Cook County Hospital since 1980 coincides with these cutbacks. Hospital reimbursement by the Illinois Department of Public Aid is determined by the patient's category of public aid. In Illinois, as a result of a 1983 public-aid cutback, total hospital reimbursement for a single hospitalization was limited to $500 for those in the General Assistance category, who receive the most limited form of public aid.[21]

Most (88 percent) of the recipients of aid from the Illinois Department of Public Aid who were transferred to Cook County Hospital were in the General Assistance category. In fact, public-aid recipients transferred to Cook County Hospital were more likely to be receiving General Assistance than were all the public-aid recipients admitted to our hospital (38 percent) in 1983 (P<0.001). Nearly half the patients transferred had no health insurance. Our study patients were also more likely to have had no insurance than all the patients admitted to Cook County Hospital in 1983 (Fig. 1).

The great majority of the patients (87 percent) were transferred because of lack of insurance. Although data on the reason for transfer were available for only 243 of the study patients (52 percent), our analyses suggest that this subgroup was representative of the entire study sample. Regardless of the service of admission or the stability status, the distributions of reasons for transfer were similar. The predominance of transfers made because the patient lacked insurance supports the contention that the increase in the number of transfers to Cook County Hospital and other public hospitals since 1980 has been attributable to economic reasons. Although 89 percent of the transferred patients were black or Hispanic, we were unable to determine whether race was a factor in the decision to transfer independent of insurance status.

A noteworthy and unexpected finding was that the proportion of the transferred medical-service patients (9.4 percent) who died was more than twice that of the patients who were not transferred (3.8 percent) during the study period (P<0.01). Although this study did not attempt to determine the cause of this mortality difference, the transferred patients may have had a different case mix or been more severely ill, or some aspect of the transfer process, such as treatment delay, may have affected outcome adversely.

Table 2. Clinical Features of Patients in Unstable Condition Transferred to Cook County Hospital

Patient's Study No.	Age/Sex	Clinical Features*
18	48/M	Pneumonia with hypoxia, PO_2 57, respiratory rate 26–33
41	46/M	Blunt head trauma with possible basilar skull fracture. Was vomiting in emergency department
52	17/F	11% first- and second-degree burns of face and chest, with respiratory rate of 44
57	30/M	Blunt abdominal trauma, with falling hematocrit and syncope. Required blood transfusion before transfer
88	64/M	Upper gastrointestinal bleeding. Jehovah's Witness, refusing blood transfusion; hematocrit 24%, pulse 144
138	28/M	Delirium tremens
157	26/F	Diabetic ketoacidosis: T 35.2°, ABG pH 7.26, PO_2 106, PCO_2 26, HCO_3 11, white-cell count 17,000/mm³
184	62/M	Acute cerebrovascular accident, stuporous, BP 198/120
187	58/M	Head trauma, confusion, pupils reacting differently, T 34.1°
220	53/F	Cancer of mouth, BP 93/65, white-cell count 20,000/mm³
225	36/M	Hypertension with epistaxis, initial BP 240/170
253	28/M	Multiple trauma with probable splenic rupture, hematuria and drop in hematocrit from 44 to 36%
290	12/M	Fell from third story, confused
304	23/M	Diabetes mellitus with T 38.3°, possible septic shoulder, white-cell count 28,500/mm³
371	42/F	Ascites, hyponatremia (serum Na 112 mmol per liter), hypoxia, ABG pH 7.51, PO_2 76, PCO_2 22, white-cell count 13,700/mm³
426	25/M	Pelvic and radial fractures, BP 90/50
515	56/M	Confusion, fever, wet gangrene of foot
539	24/M	Acute abdomen with free air under diaphragm on x-ray films
540	57/M	Pneumonia with hypoxia, PO_2 56, respiratory rate 28
576	37/M	Hemoptysis (700 ml), hemoglobin 11.5 g per deciliter

*PO_2 denotes partial pressure of oxygen, T temperature expressed in degrees Celsius, ABG arterial blood gas (values expressed in millimeters of mercury), PCO_2 partial pressure of carbon dioxide, HCO_3 bicarbonate (values expressed in millimoles per liter), and BP blood pressure expressed in millimeters of mercury.

The absence of a difference in the mortality of transferred as compared with non-transferred surgical patients may have resulted from the preponderance of patients with trauma in the surgical group. It is well known that mortality among such patients is highest during the first three hours after injury, when 80 percent of deaths from trauma occur.[22] Thus, the most severely injured patients with trauma may not have survived long enough to be transferred to Cook County Hospital.

According to our criteria, 24 percent of our study population were in an unstable condition at the transferring hospital. It is often difficult to determine the severity of illness and the potential stability of seriously ill patients.[11,23] Objective severity-of-illness scales are available for specific types of illnesses,[24-26] but there are no scales that have been tested prospectively in a population with the diversity of conditions that ours represented. Thus, the criteria we used involved the clinical judgment of trained physicians about the urgency of immediate medical or surgical treatment.

Our requirement that all reviewing physicians agree selected against the likelihood that a patient's condition would be classified as unstable. There was uncertainty about the condition of 39 patients, and they were classified as being in a stable condition. Thus, the 106 patients we classified as being in an unstable condition may have represented an underestimation of the total number of patients in unstable condition who were transferred to Cook County Hospital during the study. That the patients classified by us as being in an unstable condition had a significantly higher mortality rate, were significantly more likely to be admitted to an intensive care unit (Table 1), and had significantly longer hospital stays (14.7 vs. 7.7 days, $t = 4.18$, $P<0.001$) than those we classified as stable suggests that our rating system is valid.

For appropriately selected patients, the benefit of transfer to another facility may outweigh the risk.[1,2] The patient-transfer guidelines of the Chicago Hospital Council stipulate that patient well-being must take precedence over all other reasons for transfer.[27] The Joint Commission on Accreditation of Hospitals requires that "[i]ndividuals shall be accorded impartial access to treatment or accommodations that are available or medically indicated regardless of race, creed, sex, national origin or sources of payment for care."[28] Our data suggest that these guidelines are infrequently adhered to in transfers to Cook County Hospital.

The mean treatment delay caused by the transfer process in this study was 5.1 hours. Although our study did not assess the effect of treatment delay on patient outcome directly, treatment delay has been shown to affect outcome adversely in patients with certain conditions.[13,14,29]

In addition to treatment delay, we reviewed the informed-consent process. The American Hospital Association's *Patient's Bill of Rights* states that "when medically permissible, a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such transfer."[30] A disturbing number of patients reported that they were not informed of their impending transfer or were not told why they were being transferred to Cook County Hospital. For most, there was no evidence of written informed consent to the transfer.

Another important issue is the financial effect on public hospitals of economic transfers. According to Cook County Hospital data for patients with a similar distribution of insurance coverage, 84 percent of the $3.35 million charged to the transferred patients, or $2.81 million, was nonreimbursable. Thus, we estimate that in 1983 the nonreimbursable costs to Cook County Hospital of providing care to transferred patients was $24.1 million, or 12 percent of the total 1983 operating budget. This does not include the cost of care for transferred patients admitted to the obstetrical, gynecologic, or pediatric services, or for inpatient transfers. Neither does it reflect the cost of care for patients referred to Cook County Hospital from other hospitals and not admitted. These nonreimbursable services represent a shift of costs from Chicago's private hospitals to a financially strapped public hospital. If our patients are representative of medical and surgical emergency-department transfers in other areas of the country, extrapolation to a national level suggests an annual cost shift of hundreds of millions of dollars from the private to the public sector. With prospects of further cutbacks in federal and state support for health care, we expect the transfer for economic reasons of patients with little or no insurance coverage to continue.

We conclude that patients are transferred to Cook County Hospital from other hospital emergency departments predominantly for economic reasons. The fact that many patients are in a medically unstable condition at the time of transfer raises serious questions about the private health sector's ability to consider the condition and well-being of patients objectively, given the strong economic incentives to transfer the uninsured. The delay in providing needed medical services as a result of the transfer process represents a serious limitation of the access to and quality of health care for the poor.

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CORRECTION

Transfers to a Public Hospital: A Prospective Study of 467 Patients (February 27, 1986; 314:552-7). The NAPS document number in the footnote on page 554 should have been "04376," not "04374," as printed.

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Special Communications

Patient Dumping

Status, Implications, and Policy Recommendations

David A. Ansell, MD; Robert L. Schiff, MD

DURING the past five years, there have been dramatic increases in patient dumping throughout the United States. Patient transfers increased from 70 per month in 1982 to more than 200 per month in 1983 in Dallas[1]; from 169 per year to 930 per year from 1981 to 1985 in Washington, DC (*Washington Post*, Feb 27, 1986, p A14); and, in Chicago, from 1295 per year in 1980 to 5652 per year in 1984. Initial reports of this escalating problem were from large urban public hospitals, and it has now also been reported in smaller cities and rural areas (*Wall Street Journal*, March 8, 1985, p 27).[2,3] Patient dumping has been recently documented at more than 40 public hospitals in Texas alone.[4] We define patient dumping as the denial of or limitation in the provision of medical services to a patient for economic reasons and the referral of that patient elsewhere. Common reasons for patient dumping include the absence of or insufficient medical insurance and the lack of an admission deposit. In addition, patients with "undesirable" conditions (such as intoxication or overdose conditions) may be the victims of patient dumping. In this article, we focus on the dumping of patients in need of emergency care.

For editorial comment see p 1519.

Several recent studies have detailed the types of patients and settings involved in the emergency department dumping of patients. A study[5] at Highland General Hospital in Oakland, Calif, found that of 458 patients transferred to the emergency department from other hospitals, 63% had no insurance, 21% had Medicaid, 13% had Medicare, and only 3% had private insurance. This study also presented evidence that a disproportionately large number of transferred patients were minorities. A study[1] of 1021 patients transferred from other hospitals to the emergency department of Parkland Memorial Hospital in Dallas found that 77% of the transferred patients lacked third-party coverage. A study[7] from Cook County Hospital in Chicago of 467 patients transferred to the emergency department from other hospitals found that the transferred patients were predominantly black or Hispanic (89%), were largely unemployed (81%), and were usually transferred because they lacked adequate health insurance (87%).

Representatives from the private health sector have challenged the contention that patient dumping is a widespread problem. They contend that case reports of patient dumping are anecdotal and represent rare isolated incidents (*Long Beach Press-Telegram*, July 6-16, 1980).[3] The three largest transfer studies[1,5,7] suggest the opposite, ie, that patient dumping is a widespread, underrecognized problem that has become accepted and institutionalized in the United States. Extrapolating from data in available studies,[1-7] we estimate that 250 000 patients in need of emergency care annually are transferred for economic reasons.

Concerns have been expressed that patient dumping will soon increasingly affect other patient populations as a result of cost-cutting efforts and of cutbacks in the funding of federal, state, and local health care programs. Patient dumping by unprofitable diagnosis related groups has been predicted[8] and dumping of Medicaid patients (*Chicago Tribune*, March 9, 1986, section 2, p 2; *Chicago Tribune*, April 3, 1983, section 1, p 5; *Chicago Defender*, Dec 14, 1981, p 3)[9] and a patient with the acquired immunodeficiency syndrome[10] has been reported.

Economic, Ethical, and Legal Issues

Rapidly rising health care costs in the 1960s and 1970s have led to efforts to decrease health care spending in the 1980s. Cutbacks in government health programs for the poor and elderly (such as Medicaid and Medicare) have been shown to have deleterious health effects. Evidence includes an increase in the incidence of low birth weight,[11,12] premature discharge of Medicare patients,[13] the worsening health status of patients following Medicaid cuts,[14] and escalating patient dumping (*Wall Street Journal*, March 8, 1985, p 27).[7]

Patient dumping has had a major financial impact on public hospitals. In Chicago, transfers to its emergency department of patients from other hospitals who required medical and surgical care cost Cook County Hospital an estimated $24.1 million in 1983 in uncompensated care.[7] If the patients transferred to Cook County Hospital are representative of the patients transferred to public hospitals nationwide, the cost to public hospitals in the United States just of transferred patients requiring medical and surgical care would be $1.04 billion annually. This constitutes a direct shift of costs from the private health sector to financially troubled public hospitals. This $1.04 billion estimate of costs would be substantially higher if patients requiring pediatric, obstetric-gynecologic, and psychiatric care were included.

Ethical and legal guidelines to protect patients from dumping do exist. The Joint Commission on Accreditation of Hospitals[15] states that "individuals shall be accorded impartial access to treatment or accommodations that are available or medically indicated, regardless of race, creed, sex, national origin, or sources of payment for care." The emergency care guidelines of the American College of Emergency Physicians[16] state that "emergency care should be provided to all patients without regard to their ability to pay." Hill-Burton legislation has set forth community service emergency care requirements for hospitals. Twenty-two states have enacted statutes with such

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features as requiring hospitals to provide emergency care regardless of ability to pay and requiring that patients be stabilized before transfer.[7] There are also precedents for legal action against hospitals that fail to provide emergency care.[8,9]

In addition, a recently passed federal anti–patient dumping law called Examination and Treatment for Emergency Medical Conditions and Women in Active Labor took effect on Aug 1, 1986.[10] This law applies to all patients who present to the emergency department of a Medicare-participating hospital. Possible penalties for violation of the federal law include suspension or termination of participation in the Medicare program and a monetary penalty.

However, in spite of the ethical and legal guidelines, measures to prevent patient dumping have many shortcomings and are often ineffective. Hill-Burton legislation includes community service of a medical emergency and no effective means for enforcement.[4] In addition, the poor are usually not aware of the Hill-Burton legislation's community service emergency care requirements; even if they are aware of these requirements, they often lack access to legal assistance.[4]

There are three central deficiencies in state laws designed to prevent dumping. The first weakness is narrowness and lack of clarity in definitions of what a medical emergency is. The second problem is defining what it means to stabilize patients before transfer. Many of the state laws allow patients with emergency conditions to be transferred once their condition has been stabilized. As stated in an editorial in the *New England Journal of Medicine*, "'stabilization' of emergency cases is a notion used by hospital managers to justify transfers for economic reasons, but it is an elusive and dangerous concept."[11] *Stabilize* is a term that should not be defined at all in the context of economic transfers, since the transfer of emergency patients always carries some risk. The third deficiency of these laws is that they often lack adequate means for monitoring and enforcement.

The federal anti–patient dumping law also suffers from these deficiencies. Its definition of an emergency medical condition uses general and vague terms. In addition, the federal law permits patients with emergency conditions to be transferred after being stabilized.[10] Although it has only recently been enacted, we believe that monitoring, enforcement, and the effectiveness of this federal law will be crippled by these deficiencies.

Moral and ethical guidelines to protect patients are being increasingly ignored by hospitals given strong economic incentives to transfer the uninsured. At many private hospitals' emergency departments, pressure is placed on physicians to refrain from admitting uninsured patients.[12,13] A patient's condition might even be misrepresented in efforts to transfer them to a public hospital.[14] The rights of indigent patients are frequently ignored in emergency departments' decisions to transfer them. At Cook County Hospital, only 6% of transferred patients had evidence of written informed consent for transfer.[1]

Medical Aspects of Patient Dumping

The medical implications of patient dumping are serious and sometimes shocking. The foremost is that patients in need of emergency care are denied appropriate treatment and are being transferred for economic reasons. This practice has been well documented at several public hospitals. Researchers at Highland General Hospital in Oakland, Calif, found that 32% of transferred patients had their well-being jeopardized by transfer, in that they either were at risk for life-threatening complications or required immediate therapy that was delayed by transfer.[3]

The administration of Parkland Memorial Hospital in Dallas has reported that indigent patients are much more likely to suffer unnecessary risk and injury during transfer. They also noted that 11 of 1021 patients died shortly after transfer to Parkland and that only one of the 11 had insurance.[2] At Cook County Hospital in Chicago, 24% of transferred patients were in an unstable condition at the transferring hospital. And, 22% of the transferred patients required admission to an intensive care unit at Cook County Hospital.[1]

These patients are often transferred without regard for the severity of their medical conditions. In one instance, an 18-year-old man presented to a local Dallas hospital and was thought to have bacterial meningitis. He was transferred to Parkland Memorial Hospital with a note on a prescription blank as the only physician-to-physician communication. On arrival at Parkland several hours after his initial presentation, he collapsed and suffered a cardiopulmonary arrest. He was pronounced dead one hour later.[15] An example of a patient transferred to Cook County Hospital in Chicago was a 41-year-old man with gunshot wounds to his head, chest, and abdomen. He was in a coma and on a respirator. The reason for the transfer was that he had no insurance.[1] These are not isolated cases; similar instances have been reported by many institutions and individual physicians across the country.[16]

At most hospitals, a patient's insurance status is clearly marked on the emergency department's record. In one Chicago hospital, a reminder to avoid admission, in the form of a 5×5-cm yellow sticker, is placed on the front of the charts of patients not covered by insurance or Medicaid.[17] One medical implication of this "insurance labeling" is that patients might be discharged from hospitals' emergency departments with conditions that actually require hospitalization.

Two other issues merit discussion. Patients with no insurance who are thought to require admission have their treatment delayed by the transfer process. This delay has been reported to be as long as 18 hours, with an average delay of five hours in transfers from other hospitals' emergency departments to Chicago's Cook County Hospital.[1] In Chicago, transferred patients requiring medical (ie, nonsurgical) care had more than twice the mortality rate of patients directly admitted to Cook County Hospital. While differences in case mix and severity of illness may have explained some of the mortality discrepancy, treatment delay may also have been a contributing factor.[1] Treatment delay has been shown to cause an increase in morbidity and mortality in patients with certain conditions, including acute subdural hematomas,[18,19] pediatric trauma,[20] bacterial meningitis,[21] and appendicitis.[22]

Another problem in the transfer process is the frequent necessity of repeating blood tests and roentgenograms after a patient has been transferred. In addition to the costs of duplicated services and the unnecessary radiation, repeating these procedures contributes to the delay in treating patients with emergency conditions. A study of 100 consecutive patient transfers found that complete medical records, laboratory data, and radiological data were sent with only 27% of the patients transferred.[6]

Finally, little attention has been given to the increased pain and suffering for patients caused by the transfer process and the attendant delay in treatment. Patients with fractured bones, respiratory distress, or acute abdominal crises and women in labor may experience extreme discomfort as they are transported.

Solutions to the Dumping Problem

Why has patient dumping increased? Thirty-five million Americans are now without health insurance, an increase from 25 million in 1977.[33] In 1982, 1.4 million US families were refused care for financial reasons.[31] In the past five years, major cutbacks have been made in the funding of government health programs. For example, 600 000 people were cut from Medicaid between 1981 and 1983.[11] The increase in dumping of uninsured patients comes at a time when the profit margin of the private hospital sector in the United States (1984 data) is at its highest level in 20 years.[32]

The first step toward solving this problem will be recognition by the private and public health sectors that patient dumping is a serious and widespread problem and that it puts patients at risk. Private hospital administrators are concerned about the financial burden that uncompensated care creates for their institutions.[21] While one of the missions of public hospitals is to provide care to the uninsured, this does not justify the practice by private hospitals of dumping patients who require emergency care. Though anti–patient dumping laws are intended to protect patients, the shortcomings of these laws, as cited above, prevent them from ending the practice of patient dumping. This is exemplified by the continuation of patient dumping in states that already have such laws,[illegible] including California, Georgia, and Illinois.[illegible] The law recently enacted in Texas (*New York Times*, Dec 15, 1985, section Y, p 18) is the most comprehensive yet passed. However, it too suffers from a dependence on and lack of specificity in such terms as *patient stability* and *emergency*.

In view of the shortcomings of anti–patient dumping laws and guidelines, we propose a policy that no patient in need of emergency hospitalization be denied admission or transferred to another hospital for economic reasons. Delaying treatment to a patient who requires emergency admission always entails some risk. This risk may range from excess and unnecessary morbidity to actual loss of life. Therefore, patients in need of emergency care should be transferred only for medical reasons, ie, when needed specialty or tertiary care is not available at the transferring hospital.[30] For such patients, we would use the comprehensive definition of emergency endorsed by the American College of Emergency Physicians.[36] This definition includes all conditions that would result in a patient being admitted to a hospital within 24 hours. Application of this definition would guarantee protection of the health of all patients in need of emergency medical care, regardless of their ability to pay.

Patient dumping is but one way that access for the poor to the health care system in the United States is limited. Laws and regulations will do little to address the inequities of a health care system that often uses ability to pay as a criterion for determining whether adequate care will be provided. Long-term solutions necessitate that there be sweeping changes in health care financing and priorities to reorient the health care system such that all people are guaranteed adequate protection of their health.

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Mr. Weiss. Thank you, very much, Dr. Ansell.

Dr. Kellermann, the tape that you played indicated that it takes two to tango. The transferring physician spoke about catheterization being the reason and yet there was a clear indication in the conversation that a heart attack, in essence, had taken place, was ongoing at that very moment, and that in fact catheterization could not possibly be administered under those circumstances. There was reference to the fact that the patient was indigent and yet the receiving physician in essence agreed to take that patient.

Dr. Ansell, in your testimony I think you said that both in the original study and the followup study, some 87 percent of the transferred patients did not have insurance coverage, and yet Cook County Hospital accepted those patients; no insurance was the reason given to Cook County.

Why, in those instances, and I assume that the tape is only indicative of other cases like it, would the receiving hospitals have accepted patients when it was quite clear that medical reasons would have, if anything, militated against acceptance, and certainly the ground for it was economic?

Dr. Kellermann. In the specific case that I played, the patient was accepted in transfer primarily on the reassurances that he was currently pain-free and that fairly elaborate precautions were going to be taken for his stability during transfer.

Despite that assurance, I would not have made that decision had I handled that particular telephone call. We do occasionally accept patients, that with hindsight, or with a different or more experienced physician on the phone, we might not have accepted. Because our information is limited, I think it is important that any responsibility and liability for a patient who suffers an adverse outcome during transfer should rest with the facility initiating the transfer. Hence, the certification process.

If it is a legitimate referral for necessary tertiary care and the patient does poorly in route, I don't have any problems with that. But if it is a referral for economic reasons and the patient does badly, we are not in a position at the receiving hospital, over the telephone, to clearly know what condition the patient is in.

I refer the committee to our other illustrative cases where we were given lavish assurances that the patient was stable.

In one case, my resident doctor even called the hospital back and said, "Wait a minute; I just heard the nurses talking to each other on the phone and this person sounds terribly sick. We don't have a vacant intensive care unit bed in this entire building." The emergency doctor in the other hospital said, "Don't worry about it; the nurse is hysterical; the patient is really stable." In fact, the patient was in terribly critical condition on arrival. She later died. So we have real information exchange problems.

We at the Med have traditionally provided care to anyone in the Midsouth area who desperately needs it. For this reason, we generally try not to get into major battles over the phone when a hospital indicates that they don't wish to provide care to a patient. We do refuse many unstable transfers and I have documented them in my report. The cases involve patients who were either too unstable for transfer, or who required an intensive care unit bed when none was vacant at the Med.

But it is not a perfect system, and I think your question, itself, points out the fact that relying on telephone screening is not an adequate substitute for an overall, general philosophy that unstable patients will not be transferred, unless they require services and care that are unavailable at the hospital where they are currently being treated. That is the only acceptable reason to transfer an unstable patient.

Mr. **Weiss**. Dr. Ansell.

Dr. **Ansell**. Yes; I think that is sort of the heart of the issue. I think one problem is there are differences among physicians about defining stability. I think that is an issue. There are other physicians who feel that unstable patients should just be transferred, regardless; if the hospital is not going to provide the care, get them here as quickly as possible—we will provide the care.

You know, I think there are real disagreements and I think that is the problem with the word "stability" and "unstable;" we are trying to define something that is really elusive and not definable. It is difficult, I think, in the situation that he described—the physician in the transferring hospital, the guy wasn't having pain, but when he came to the hospital he was having pain. You eliminate that condition from being transferred by preventing economic transfer.

There are multiple medical conditions. There are hundreds of things that people come to the hospital with and I think that reasonable people will disagree about which patients are stable and which are not, whether they be economic transfers or noneconomic transfers. That is why we emphasize that if that transfer is made to provide services otherwise not available, then that sort of degree of uncertainty won't affect patient outcomes.

Mr. **Weiss**. Right, but in the study that you reported, it occurred before the adoption of the COBRA legislation, and I don't know whether stability was a factor.

Dr. **Ansell**. Let me just explain. In Chicago, since 1977, there have been very explicit guidelines, similar to those that are currently adopted in Dallas, which outline appropriate reasons for transfer. Included in that was the patient's stability as being one of the prerequisites. Unfortunately, that goes against what is possible or even desirable for many patients.

Mr. **Weiss**. But, you said that the patient was told one thing, and the receiving physician was told something else. What the receiving physician was told in 87 percent of the cases was that the patient had no insurance coverage. The decision was not being made on either side, as between the professionals, on the basis of stability of condition, but on the basis of economics.

Dr. **Ansell**. But you see, you have differences of opinions, even within the hospital. Even within our hospital there are those who say—I don't want you to spend any time stabilizing a patient because that is going to delay that patient's treatment; if you are not going to treat the patient, send them here. There are differences of opinion, even within that context.

Mr. **Weiss**. Is it your position that had Cook County Hospital said, "Sorry, economics, lack of insurance coverage is not good enough—we are not going to take that patient," that the transferring hospital would have in fact discharged that patient in any event?

Dr. **Ansell**. Let me just speak about two things. One is, responsibility in these situations comes in an individual phone call, a personal relationship from physician to physician, about an issue that is really a health policy issue. On an individual basis, we are making decisions that are sometimes right and sometimes wrong.

For example, at Cook County Hospital, the official policy is to accept indigent transfers. We are a hospital to provide care for the indigent. And so the lines do blur. Well, this patient is indigent—do we accept the transfer? Few transfers are refused routinely. I think what you see is the volume of transfers has just increased so much over the past few years. I don't think it is a new problem. The volume has increased so much—I don't think individual physicians is the place where the decision needs to be made.

I think it needs to be a policy, and that is why I am arguing for clear-cut policy, that sets the terms, and I think the terms need to be that the patient needs services that are not at this hospital—then it is OK to transfer him. It makes it very easy—and then stability doesn't matter, because you will transfer an unstable patient in that situation.

Mr. **Weiss**. Dr. Kellermann has pointed out the difficulty that they have in Tennessee in trying to get that kind of legislative change. What, if anything, has happened in Chicago or Illinois on that subject legislatively?

Dr. **Ansell**. Nothing. Since the publication of our article, nothing has happened. There is a State law that requires emergency care, but it is vague. It doesn't define emergency, it doesn't define what emergency care is.

Emergency care means more than care in an emergency room. It may mean care in a hospital, in an intensive care unit, or an operating unit. So really nothing has happened. We have a State law and we have local guidelines, and yet it continues to be a problem.

Dr. **Kellermann**. Mr. Chairman, I would add to my earlier comments on your question about the economic issue and the role of both the sending and receiving hospitals. In many communities with publicly supported hospitals—whether they are run by private corporations or publicly owned—there is a very clear set of expectations or a consensus that has existed for decades that the poor in that community are the sole responsibility of that public hospital, even if they are in an emergency condition and come into another facility. That belief, that conviction, is oftentimes echoed in my own residents, interns, and some of my fellow faculty as well. Therefore, when a resident receives a phone call, "I have an indigent patient here who is having a heart attack, but now he is pain-free," it is perceived as our responsibility to go ahead and take that patient, even in a fairly emergency condition, unless they are so grossly unstable that any one would agree that to accept the patient would be a very foolish thing to do.

That attitude can get very pervasive. An example of it occurred yesterday, when I received a letter requesting payment from a very wealthy private hospital in town. It is a not-for-profit institution, but it had net revenues of $17 million last year in comparison to our losses of $7 million. They were sending us a bill for two patients who were "Shelby County indigents" that they admitted at a point in time when our hospital was filled to capacity and we would not accept them as economic transfers.

This hospital expects that we will pay out of our revenues or operating funds, the medical bills of these two patients since they went ahead and admitted them to their hospital, after we refused the patients because we lacked available beds. That is the mindset that we have to deal with.

Mr. **Weiss**. That is important. I wanted to get that context into the record.

Dr. Kellermann, as we heard from Ms. Hill earlier, Terry Takewell died from complications related to diabetes after the Methodist Hospital in Somerville, TN, refused to treat him. Was any action taken against the hospital, do you know?

Dr. **Kellermann**. That case was reviewed on the State level by the Tennessee State Board for Licensing Health Care Facilities. That is the same board that received our proposals and recommendations regarding antidumping regulations in Tennessee.

There was an excellent, very well conducted investigation by the deputy counsel for the Department of Health and Environment in Tennessee, which resulted in a long list of allegations against the hospital. All but two of those allegations were not upheld by the board and the case was largely dismissed with only corrective action recommended for general management of patients.

I would add that the composition of this board in Tennessee, by statute, is that 10 of the 13 members of the board must be representatives of the very institutions and professions regulated by the board. While I cannot speak to the objectivity or lack of it in this particular case, I will say that a couple of old county prosecutors that I have dealt with in Tennessee have always told me that it is foolish to attempt to try a man when his kinfolk and his neighbors are on the jury.

I think you are dealing with a similar situation when you go to a State agency with that type of composition. Objectivity can be quite difficult.

Mr. **Weiss**. Dr. Kellermann, HCFA has adopted a policy of relying on the State agencies to investigate complaints of patient dumping, rather than using Federal resources. In your opinion, does the State agency in Tennessee have the will and resources to carry out this responsibility?

Dr. **Kellermann**. In the case of Tennessee, the State agency in question would again be the Board for Licensing Health Care Facilities. For the reasons that I just addressed, I do believe that while that board would in fact have the resources—they have excellent staff at their disposal—I am not at all confident that they would have the will to vigorously enforce the regulations of COBRA.

Mr. **Weiss**. I think one or both of you may have already answered this question, but let me get it for the record clearly. Has the new Federal law, that is the COBRA legislation, had any impact on your hospitals?

Dr. **Ansell**. None.

Mr. **Weiss**. Dr. Kellermann.

Dr. **Kellermann**. I have seen no perceptible impact whatsoever.

Mr. **Weiss**. Would you be able to tell us why you think it has had no impact?

Dr. **Ansell**. I don't think anybody knows about it, No. 1; and two, I believe, as written, it is unenforceable. We have actually called HCFA to see what the rules and regulations are, and have not been able to get them.

I wanted to read them but I don't think they will be enforceable because of the problems of the definitions in the law. We haven't seen anything.

Mr. **Weiss**. Dr. Kellermann.

Dr. **Kellermann**. For several of the reasons outlined earlier, I think that patients aren't going to file complaints. I think many hospitals are very reluctant to get into a major battle with their neighbors, and I think that the lack of any actual regulations to implement the law has really crippled its potential effectiveness.

For all those reasons, I think basically we have a very worthy piece of paper that has not worked at this point in time. It will not until we put the teeth into it to make it work.

Mr. **Weiss**. Again, this is to both of you. Do you believe that physicians who witness dumping feel reluctance to be whistleblowers, that is, to charge another hospital or another physician with violating antidumping laws?

Dr. **Ansell**. That is a hard question to answer. I think I can speak for physicians I know in my institution; I think it is more of a frustration. I thought about it a little bit coming over here today.

You know, people are working, say in the context of Cook County Hospital—there are hundreds of patients; you are very busy. These cases come in; there is really no official place to turn to. There is no clear-cut mechanism to protest. You do it within the administration and it is the administration's responsibility to take that somewhere.

It is kind of a haphazard procedure. I think that the physician out there in the trenches, faced with all these patients, and just trying to do his job of being a physician—I think this kind of process interferes with that, and I think both with notification of potential violations—that means taking an extra step beyond what you would normally do. This also occurs when someone wants to transfer such a patient to you. You have to fight, you have to struggle to deny a transfer, and you have enough work to do and it is hard enough to do that.

That is why we need some kind of external kind of support for this.

Mr. **Weiss**. Dr. Kellermann.

Dr. **Kellermann**. I think as Ms. Waxman said earlier this morning, there really are a lot of unfortunately encumbering local political considerations that oftentimes get entered into that decision. Many times, administrators in hospitals will say, "We understand; that was a terrible problem. We support your wanting to file a complaint, but we are trying to work out a trauma center designation system in the area," or "We are trying to work out some referral mechanism," or "We are trying to work out some method of compensation," or some other very major political issue in the community, "and we need the cooperation of those other hospitals. If we file the complaint right now, we will lose that. So let's just send a letter over there; we will get them together at lunch and try to talk to them about it." There is just a real reluctance to invoke a full-scale Federal investigation.

I think that complaints should be filed in particular cases. One way of dealing with the reluctance to file would be to have an ongoing process that requires documentation and filing of transfer reports and have periodic auditing of those files to detect cases independent of whether they are reported by the transferring or receiving hospital or not.

We keep such files. We even keep files on the cases we refuse and the reason that we refuse them, in the event that later we are criticized for not accepting a patient in transfer. I think every hospital in this country should keep such records.

Mr. **Weiss**. What is the best way, in your opinion, to let patients know their rights and how they may file a complaint about the hospital if they have been transferred inappropriately?

Dr. **Ansell**. I don't know the answer to that. I think providing informed consent and letting people know at the time of the transfer, and letting their families' know—I mean, I would say that we should not have transfers for economic reasons, but if you are going to allow that practice to continue, then at the time of transfer, people should be informed of what their rights are, afterwards, and informed that they have a right to hospitalization at this hospital.

That would be the only thing. I don't know an easy answer to that question.

Mr. **Weiss**. Dr. Kellermann.

Dr. **Kellermann**. I have proposed, out of a sense of frustration, that my hospital adopt a unilateral policy requiring informed consent, in writing, prior to our accepting the patient in transfer. This is currently undergoing internal review.

I would suggest that any consent document include reference to COBRA, or reference to the future regulations that are written and state that the patient acknowledges that they have a right to refuse transfer for nonmedical reasons, et cetera. That is probably the best way. I can't see a real, mass public education program being effective.

I think you have to educate the person at the time that transfer is being proposed to them. They need to understand the real reasons for the transfer, as well as the risks and expected benefits of transfer.

Mr. **Weiss**. What should be done to prevent reverse dumping, which is the refusal of patients for emergency treatment by a tertiary care center? Dr. Ansell.

Dr. **Ansell**. Could you restate the question?

Mr. **Weiss**. Suppose a hospital which says they don't have the technical or scientific facilities to deal with the particular illness or problem of that patient calls a second hospital with the necessary equipment and the second hospital says we are not going to take that patient.

How do you deal with that problem of reverse dumping?

Dr. **Ansell**. You know, we encounter that once in awhile. We are a tertiary care center, so that is not too much of a problem, and I don't know how to deal with that.

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In some ways, there is a larger problem which is how do you deal with people who end up in an emergency room and get sent away with a little slip of paper, and then show up the next day, 24 or 48 hours later, in your county hospital emergency room with a slip of paper. In terms of magnitude that is probably a much greater problem.

Mr. WEISS. Dr. Kellermann.

Dr. KELLERMANN. I do think it is uncommon. In Memphis, we don't have that problem because private hospitals require that we guarantee payment out of our operating revenue to them for any patient that doesn't have adequate insurance, regardless of our reason for referring them.

I think that on a national level—in particular communities in rural areas—it may involve, Congressman Lightfoot, refusal to receive a rural patient with a bad farm injury, for example, at a major tertiary care hospital. I think, again, records need to be kept not only in cases of actual transfer, but also when a transfer is requested and refused, the reason for refusal. If there is a problem in that case, or an audit suggests that there may have been a problem, then that hospital needs to explain why they refused the patient and be held accountable, if necessary.

It can be accomplished with the same auditing process that I referred to earlier. It's bureaucratic, I know. Any time you have people coming in and nosing through someone else's books, it involves a little extra work. But I think if the intent of these regulations are to protect the patients rather than to protect the hospitals, it is going to take an auditing process before we are really going to have effective regulations.

Mr. WEISS. Thank you. Dr. Ansell.

Dr. ANSELL. I just wanted to say, we have been in the ironic situation on occasion, of having a patient transferred from a hospital because of lack of insurance, and then needing to be transferred back to that hospital for a specialized test, or for admission to an intensive care unit for some reason.

It is ironic, and I think that the county pays for it in Cook County, but you can see what that does for a patient.

Mr. WEISS. Thank you. Mr. Lightfoot.

Mr. LIGHTFOOT. Thank you, Mr. Chairman. Dr. Kellermann, earlier when I asked Ms. Waxman about the motivation behind the Texas law, I noticed you perked up in the audience. I thought maybe you had a response that you would like to put on the record.

Dr. KELLERMANN. I would like to acknowledge the individual who put a lot of his heart and soul into it. That is Ron Anderson. His work lead to the Texas law. He is a physician, also an administrator, for Parkland Memorial Hospital and he, I think, deserves in large part the credit for what has happened in Texas and he has inspired a lot of our work around the country.

It is a shame, really, that he was not here today. I think he really is the one that took the battle to heart much earlier than any of us.

Mr. LIGHTFOOT. He will appreciate those comments.

One question that nags away somewhat, because we are all here for the purposes of trying to provide the best care we can for the people involved, but in your opinion, as physicians, do we get into a crossed swords position where regulation usurps clinical judgment? I know clinical judgment is something that physicians value very highly, as they should.

Are we going to get at cross purposes here in this law and how do we resolve that particular situation? Many of these things, I assume, have to be judgment calls just by the nature of the particular situation. How do we know when someone is stable? Are there specific parameters we can put together so that you can go to the book to find out, so to speak?

Dr. **Kellermann**. I don't think you can write a cook book. There are so many different ways, so many different permutations of the human condition that you could not possibly write them into statute. I think the best that you could come up with, perhaps on a review basis, would be, as is done in malpractice cases, to refer to a State standard of care or a national standard of care. You may end up in a given case having to hear expert testimony or expert review by physicians, uninvolved politically or medically with the case, to look it over and say, "Yes, this was appropriate, and this was a proper transfer," or, "My God, this was really outrageous."

One of the cases that I included in my report was a patient with life-threatening diabetic ketoacidosis. The transfer was actually initiated within an hour of his arrival at a very wealthy Memphis hospital that had revenues in millions of dollars last year. It occurred at 11 a.m., in a half empty ER, that was not busy and was certainly not going broke. Nonetheless, the transfer was initiated and the patient was sent before we authorized transfer.

When I filed a very strong complaint with that hospital, their response was, "We have looked over the case and he was obviously stable; what are you talking about?" Now, I am not sure which planet they are on, but it was like we were talking two different languages. I would welcome an independent physician review of that type of transfer, and I think that that is what it is going to take.

Dr. **Ansell**. I will second that. We have had the same kind of experience in Chicago. You get cross purposes, and that is why the best thing might be to limit physicians to making clearly medical judgments, independent of the financial condition of the patient in these emergency cases.

I think that would make things a lot easier. I keep arguing for that, because I think you get into these areas of conflict—this other factor gets entered in there, a pressure factor—the financial status of the patient and what the hospital is going to do.

One hospital in Chicago has a sticker on the chart when the patient has no insurance. When you see the patient, you know the patient has no insurance. That may affect your medical judgment. You may say, the patient needs to be hospitalized, but I have to call County and they may refuse the patient. I will send the patient home.

I just think when a physician is put in that situation, and I think emergency room physicians will tell you, it is a very uncomfortable position to be put in, and I don't think they should.

Dr. **Kellermann**. I do think, because it didn't come up earlier, there are a couple of quick, important corollary points that need to be added.

One of them is that many times—while we have talked about emergency room physicians today, sometimes they are almost as much the victim as the patient. The emergency room physicians are laboring under oftentimes verbal, rarely written, policies set forth by their hospital administration that explicitly state, "You will not admit a patient who lacks any insurance." To do so is going to get them in hot water with their employer.

So they are really caught in the vise. That is why I was very glad—despite the fact that we have been picking at COBRA all day—I was very pleased that COBRA listed explicitly in its language that both the hospital and the physician would be held accountable in those patient dumping cases.

In fact, I understand that in Texas, there has been pressure by the hospital association to absolve the hospitals and only go after the physicians, which I consider to be an interesting abdication of responsibility.

I would add that sometimes the ER physician is also trapped by the private doctor or the admitting physician. We work in the emergency department. I don't go upstairs and admit patients. I stabilize them, treat them and turn over their care to another physician.

In many private hospitals, I have had ER doctors call me and say, "Dr. Kellermann, I am sorry. I can't get a doctor to come in tonight and admit this patient. No one will admit this charity case. Will you please help me. I don't have anywhere else to turn to with him. I can't get a private doctor to admit him."

It is not always the emergency physician's fault in these cases. That doesn't speak well for my profession, and I am ashamed of that. But, as we get more and more under financial, commercial, and competitive pressures, and everybody starts worrying about the bottom line financially, we are beginning to forget that the very, very first consideration should always be to care for the emergency patient. Treat first, and worry about finances later; not the other way around.

Mr. LIGHTFOOT. While we are on that line of thinking, do you think that financial pressures are going to outweigh political pressures, as far as not reporting violations?

Dr. KELLERMANN. I think they certainly could. That is why you have to have an independent mechanism, almost, to pick these things up. Hospitals will stop dumping when either of two things happen; either we fix the national health care system and make health care available for all—and, absent a major reprioritization of everything in this country, that is not likely to happen real soon—or the other way that hospitals will stop dumping is when the penalties render it against their financial and political interests to do so. As long as the margin favors transfer rather than keeping the patient, they will continue to transfer.

I think we simply have to engineer the system such that it is in the private hospital's interest to keep that patient, rather than to transfer that patient, since they will suffer greater penalties by transferring than they will by just accepting the fact that they may have to provide some more uncompensated care to an emergency patient.

I am not talking about health care on demand. We are not talking about a patient with no money who wants a tummytuck or a face lift. We are talking about heart attacks and seizures, and strokes and gastrointestinal bleeding—emergencies that need care then, that can't wait later.

That is the patient that I think we are all talking about today.

Mr. **Lightfoot**. I suppose, going back to what we were talking about a moment ago, that in a pure sense, the type of atmosphere that physicians would best function in and probably would prefer to function in is where the only judgment that they have to make is medical decisions as to what that patient needs or does not need, that they are just a human being in trouble and you are there to try to help them in any way you can.

In this process, can a physician be put in that kind of a vacuum, so to speak, where you don't have a sticker on a chart that says this person can't pay, or whatever? Can they be taken out of the loop that far?

Dr. **Ansell**. I don't think in the way in which health care has been defined in this country increasingly over the past few years that that can occur without some directive; that for these types of patients, this won't occur.

I don't see any other way. There is pressure at the public hospital. There is local political pressure against us to say that dumping is not a problem; there is the financial pressure. On the individual physician basis, his or her hands are in many cases tied. So it has to be some sort of directive, I would think.

Mr. **Lightfoot**. Doesn't that force you into an administrative position to a great extent which is maybe above and beyond the call of duty to some degree?

Dr. **Ansell**. It may, but I think the issue here is patients—emergently ill patients who need to be hospitalized, whose medical conditions may depend on the nonmedical steps that you take that might delay transfer.

I think that we have to protect the patients and this is the only way we can protect all these patients.

Mr. **Lightfoot**. In Ms. Hill's testimony this morning, they took him to the doctor and as I read the testimony, the doctor picked up on the diabetes situation and recommended he go into a hospital. Of course, then it was stopped later on.

In an emergency room type situation and looking through—I don't mean this as a derogatory remark, but looking through your testimony from the type of people that come in, it looks like you are almost in a war zone sometimes: stab wounds, shots, and people falling out of windows, and this type of thing.

That has to put a lot of pressure, I would think, on people working in an emergency room, and then to have to make these kinds of decisions on top of that. That is a bit unfair.

Dr. **Ansell**. The interesting thing about these patients, they were transferred to other emergency rooms and then were secondarily transported to Cook County Hospital. They were presented to emergency rooms somewhere else in the city.

There is a lot of pressure and, again, it is not easy to know what a clear-cut solution can be.

There are so many different angles from which this occurs. We are just talking about emergency patients.

When I knew I was coming for this testimony, just in the past 2 or 3 weeks, I came across five or six cases—not all of them were emergency cases, some in-patient transfers. One patient who was an Iranian and was in a car accident at a hospital about 15 miles away from Cook County. They found out he had cancer at the base of his tongue and removed his tongue, and he had respiratory distress.

He just showed up at the emergency room at Cook County Hospital unannounced. I happened to be going into the hospital and saw him going up the stairs with a bag from that hospital. Cases like this are not common. It turns out, independently I found out that the social worker at this hospital said—oh, we have been trying to get rid of that patient for months, because he was a financial burden on the hospital.

There is a human element that gets missed in here, and somehow we have to bring that back to the forefront because that is what doctors are best at—taking care of patients. The rest of it gets into sort of a cloudy zone, and we are not good at making these kinds of decisions.

Mr. LIGHTFOOT. There are no black and white answers.

Dr. KELLERMANN. I really do think that the physicians in private hospital emergency departments are caught in the middle. I absolutely and fundamentally believe that if my colleagues could be insulated from the financial and political considerations of accepting a patient and admitting him to their hospital, they would do it in a second.

I don't think anyone goes through 4 years of medical school and 3 to 5 years of residency to turn people away.

I think it is a gut-wrenching decision for any doctor in this country to have to make, and a very, very difficult one for any doctor with any degree of conscience. But they are being put under tremendous pressures by the institutions and organizations that they are working for.

I am the president of the Tennessee State Chapter of the American College of Emergency Physicians, and while I am not speaking for them, many of my members do work for private hospitals. They are good people, but they are trying to play by a very, very tough set of rules, and I don't envy their position.

In a publicly subsidized hospital, I am insulated, in a way, from a lot of those considerations. I have the moral high ground of being able to say to anyone that comes to my door from Mississippi, Arkansas, or another west Tennessee county that doesn't pay any money, that it is OK. Our philosophy is we always take care of the patient; we never send them back. We never deny access to a patient who is in an emergency condition, and I can go home and go to sleep at night.

I may be beat to death from being in a war zone, but I haven't had to look anybody in the eye that day and say, "You are going to hospital B." I don't envy the people who have to do that, or feel like they have to do that.

I think we need to make sure that the institutions that those physicians are working for are the primary party that is held accountable, because I don't believe that the physicians, themselves, are making that decision independent of institutional policy, either written or unwritten.

Mr. **Lightfoot**. One last question. Dr. Ansell, you made a comment earlier that there are some rural transfers taking place, and so on. Are you aware of any studies that have been done along that line that we could review to see what the numbers are?

Dr. **Ansell**. No. Just the anecdotes, and I think it would be a useful place to look. As was mentioned, I think Ms. Pelosi mentioned about AIDS—there have been reports of AIDS dumps, a number of them.

Dumping occurs when you have something that is undesirable about you. It could be financial or it could be in certain instances medical. I think it is something that we have to keep our eyes on. I think the rural issue needs to be explored.

Mr. **Lightfoot**. I appreciate it. Thank you, both of you gentlemen. Thank you, Mr. Chairman.

Mr. **Weiss**. Thank you. Ms. Pelosi.

Ms. **Pelosi**. Thank you, Mr. Chairman.

My question regards the difference in facilities in some of these hospitals we are talking about. Just on the face of it, we have all agreed and you said that no one should be transferred unless it will improve the lot of the patient.

Private hospitals do not have some standard procedures to deal with some of the conditions on the list? Or, they can maintain, at least, that they do not have facilities to deal with these problems?

Dr. **Ansell**. There are some private hospitals that for certain types of patients do not have facilities, or adequate facilities to take care of those patients. Decisions then should be made to transfer that patient to the closest facility that has the appropriate facilities.

A lot of patients, even though they seem like they are in severe medical condition, all they really need is a doctor who will minister to them. That is really all they need.

In Chicago we have a regional trauma system which takes the most severely injured patients from the site of the accident to the regional trauma unit. Even despite that, which is a good concept and a concept should apply to all emergently ill patients—you should be taken to the nearest place that can take care of you—despite that patient dumping still occurs.

Ms. **Pelosi**. In Dr. Kellermann's example, cardiac catheterization, is that an unusual procedure?

Dr. **Kellermann**. It is not a procedure that is done at every hospital. In this particular case, interestingly, the hospital in question is a satellite facility for a major, downtown central hospital of the same corporation, and the central hospital advertises itself as a national leader in cardiac procedures.

Our hospital, in fact, does not have cardiac catheterization facilities, but pays on a contract basis to a neighboring institution to do them.

The argument in this case, the taped transfer, becomes gray because the hospital the patient was coming from does not perform cardiac caths. They could have sent the patient to their central hospital, which would have been the transfer destination of choice, if anything were going to be done transferwise. But, in fact, given the procedure we discussed earlier, the patient really didn't require transfer. He did not need to be moved for the first several days, and could have been cared for very effectively at the original hospital.

This is a really important point. It is difficult on a case-by-case basis to sort out when the referring facilities are adequate and when they are not. We have to be very careful, Dr. Ansell and I, for occasionally people misperceive our comments and believe we are arguing against transfers of any sort. Clearly, particularly in the case of trauma patients, regionalized trauma centers are very important mechanisms for the appropriate and speedy care of patients. These cases oftentimes involve transfer from lesser or lower centers of care to a regional center of excellence. In most cases, these trauma centers are housed in county or publicly subsidized hospitals, though not invariably.

Ms. Pelosi. But nonetheless, most of the cases of dumping could have been handled in the hospital, or the people could have been transferred to a closer hospital if the first hospital did not have the services.

Dr. Ansell. The overwhelming majority, from our study, had conditions that could be adequately taken care of in the hospital that transferred them.

Those patients—we even looked at our unstable patients, saying—OK, this is the worst case scenario. Let's argue for a second that there is some degree of appropriateness, which even for the sake of argument that I don't think is that valid, but even if you look at those, 35 percent came from tertiary care hospitals. Ninety-nine percent of those patients bypassed a closer hospital that had appropriate facilities. It supports our contention that the reason for transfer was economic.

Dr. Relman mentioned this issue, and I think we should talk about it. This mostly affects the indigent, but the opposite of dumping is skimming; deciding a hospital admission based on economics can work both ways.

Our patients who are transferred to Cook County Hospital were poorer than even the patients who came to the front door of Cook County, which suggested to us one possibility was that they were skimming the paying patients off, and then transferring these nonpaying patients. That is unacceptable, also.

I don't know how one gets to that issue, but medical care has to be the common denominator for any transfer.

Ms. Pelosi. I would think that some of these indigent patients are not likely to make a big public case about getting taken care of in the hospital if the cause of their going to the hospital in the first place might be a source of some embarrassment to them, through no fault of their own.

So it seems to me that there needs to be something in the regulations that again addresses the rights of these individuals. Whatever the political situation is, and whatever the financial situation—because of hospitals, or doctors, or what their future needs are—some of the people just personally do not seem like they are likely to speak up.

Would you agree with that?

Dr. **Ansell**. Yes, I would agree with that. These are, in a lot of cases, the disenfranchised, and who are sick. I think they are the least likely to know what their rights are and what they can do. Again, in terms of legislation—this is just the tip of the iceberg. This is a bandaid to a particular aspect of a problem when large numbers of people don't have access to routine types of health care.

I think if we can solve this, you know, this is a very glaring example, and I think a very poor show for our country.

Ms. **Pelosi**. Thank you, Mr. Chairman.

Mr. **Weiss**. Thank you, Ms. Pelosi. Again, I want to express the subcommittee's appreciation and my personal appreciation to both of you for coming here, and for sharing your knowledge and expertise and wisdom with us.

Dr. **Kellermann**. I thank you on behalf of our patients. We appreciate your interest and that of the committee on this issue. Thank you.

Mr. **Weiss**. Thank you.

The subcommittee will now stand in recess until 2:15 p.m.

[Whereupon, at 1:15 p.m., the subcommittee recessed, to reconvene at 2:15 p.m., the same day.]

AFTERNOON SESSION

Mr. **Weiss**. Good afternoon. The subcommittee is now back in session. Our next panel will be Dr. William Roper, who is Administrator of the Health Care Financing Administration in HHS; Richard Kusserow, inspector general for HHS; and Audrey Morton, Director for the HHS Office for Civil Rights.

Before we continue, would you please stand and raise your right hand to be sworn in.

[Witnesses sworn.]

Mr. **Weiss**. Let the record indicate that each of the witnesses has responded in the affirmative.

Dr. Roper, I understand that you have an opening statement. We will commence with you, and then proceed to questions.

STATEMENT OF WILLIAM L. ROPER, M.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY RICHARD P. KUSSEROW, INSPECTOR GENERAL, AND AUDREY F. MORTON, DIRECTOR, OFFICE FOR CIVIL RIGHTS

Dr. **Roper**. Thank you, Mr. Chairman. As I said to you just a moment ago, I apologize for keeping the subcommittee waiting. I am going to present a joint statement for the Department of Health and Human Services.

With me today are the inspector general, Mr. Richard Kusserow, and the Director of the Office for Civil Rights, Ms. Audrey Morton, and we will be pleased to respond to your questions.

We are here to discuss the important issue of patient treatment in hospital emergency rooms. Our Department is committed to assuring that all patients needing emergency medical care receive prompt and appropriate treatment, regardless of their financial circumstances.

We are especially pleased to have the chance to discuss our implementation of section 9121 of the COBRA legislation, otherwise known as the antidumping legislation. In addition, we will discuss the Hill-Burton Community Assurance Program, and the present status of the Department's implementation of these laws.

COBRA added a new requirement to the Medicare law, effective August 1 of last year, for all Medicare participating hospitals with emergency rooms that would assure corrective action or penalize hospitals that refuse to treat all patients who seek treatment in emergency rooms with emergency medical problems.

This legislation was enacted because you, the Congress, were concerned about the increasing number of reports that hospital emergency rooms were refusing to accept or treat patients with emergency conditions if the patients did not have the means to pay.

This section of COBRA amended the law to require Medicare participating hospitals with emergency departments to provide appropriate medical screening and treatment for all individuals with emergency conditions, and women in active labor, and to provide medically appropriate transfer to another facility when indicated.

The enhanced enforcement mechanisms authorized by COBRA protect individuals who seek treatment in hospital emergency rooms and ensure that they are medically evaluated, properly treated and, if appropriate, properly transferred. Failure of the hospital to treat or stabilize a medical emergency within a hospital's capabilities will jeopardize that hospital's status as a Medicare-approved institution.

COBRA provides for three responses if there is a problem. We may terminate or suspend the hospital agreement, thus ending or interrupting their involvement in the Medicare Program. It provides for civil monetary penalties, up to $25,000 for each case, and civil actions may be initiated by the patient or other hospital up to 2 years after the violation.

Under the termination procedures, the hospital has an opportunity to take corrective action immediately, and remedy the problems that cause the violation, thus assuring that quality is maintained and access to health care is not interrupted.

The legislation also provides for suspension of the hospital's Medicare provider agreement. Termination is oriented toward compliance and, by contrast, suspension could be used for compliance, as well as a sanction or a penalty for past acts. Both of these tools are intended to protect patients from being dumped, and to deter unlawful dumping in the future.

Under a separate statutory provision, the Department has the responsibility to ensure that hospitals who received loans under Hill-Burton provide medical care to all individuals in their community. Hill-Burton assisted facilities are required to make their services available to all persons without regard to race, color, national origin, creed or any other ground unrelated to the need or availability of the service.

This requirement under Hill-Burton relating to the provision of emergency services prohibits a Hill-Burton facility from denying emergency services to any person who resides in that facility's area.

A review of the problem of patient dumping must consider the realities of the changing health care environment. It, for example, should not be assumed that increases in patient transfers necessarily mean patient care has deteriorated.

We know that many patients who seek care in emergency rooms do not have urgent or unstable medical problems, and could appropriately be transferred to other treatment facilities. COBRA clearly intends the provision to apply to persons whose conditions are unstable, or whose health could be placed in jeopardy without prompt treatment.

The goal of our policy is to ensure that emergency rooms provide appropriate evaluation or treatment, or transfer such patients only after they are medically stable. We emphasize that we are committed to assuring all patients the right to receive prompt and appropriate medical treatment.

If I could, Mr. Chairman, just make a couple of comments in addition. We look forward to responding to your questions and enlarging on specific cases that we have received, our investigations of those cases and how we have handled them.

We are vigorously enforcing this provision of the law. We feel like it is important and are pleased to be doing what we are doing. I understand Mr. Stark, in his testimony this morning, pointed to some problems in the language of the legislation that may need clarification.

We are glad to hear of his interest in that area. My colleague, Mr. Kusserow, has made some recommendations for clarification that I support, but let me be clear in making that statement, the problems in language have not impeded our ability to act aggressively, to protect people who seek care in Medicare hospital emergency rooms.

Further I am told that there have been some before you today commenting on the fact that we have not yet fully promulgated the regulations called for under this legislation.

We take seriously writing regulations and we are drafting these regulations and will publish them shortly. But let me emphasize firmly that the absence of fully promulgated regulations has not kept us from using this important new statutory tool to protect people who seek care in emergency rooms in Medicare hospitals.

With that, let me pause and turn to my colleagues.

[The prepared statement of Dr. Roper follows:]

STATEMENT OF
THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEFORE THE
HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
OF THE
COMMITTEE ON GOVERNMENTAL OPERATIONS
HOUSE OF REPRESENTATIVES
July 22, 1987

WE ARE PLEASED TO BE HERE TODAY TO DISCUSS THE IMPORTANT ISSUE OF PATIENT TREATMENT IN HOSPITAL EMERGENCY ROOMS. THE DEPARTMENT IS COMMITTED TO ASSURING THAT ALL PATIENTS NEEDING EMERGENCY MEDICAL CARE RECEIVE PROMPT AND APPROPRIATE TREATMENT REGARDLESS OF THEIR FINANCIAL CIRCUMSTANCES. WE ARE IMPLEMENTING THE RECENT PENALTIES THAT WERE AUTHORIZED BY THE CONGRESS AGAINST HOSPITALS THAT FAIL TO ADEQUATELY TREAT PATIENTS WITH EMERGENCY MEDICAL CONDITIONS OR WOMEN IN ACTIVE LABOR.

WE WOULD LIKE TO DISCUSS THE IMPLEMENTATION OF SECTION 9121 OF THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA), OTHERWISE KNOWN AS THE ANTI-DUMPING LEGISLATION. ADDITIONALLY, WE WILL DISCUSS THE HILL-BURTON COMMUNITY ASSURANCE PROGRAM, AS WELL AS PRESENT THE STATUS OF THE DEPARTMENT'S IMPLEMENTATION OF THESE LAWS.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) ADDED A NEW REQUIREMENT, EFFECTIVE AUGUST 1, 1986, FOR ALL MEDICARE PARTICIPATING HOSPITALS WITH EMERGENCY ROOMS THAT WOULD ASSURE CORRECTIVE ACTION OR PENALIZE HOSPITALS THAT REFUSE TO TREAT ALL PATIENTS WHO SEEK TREATMENT IN EMERGENCY ROOMS WITH EMERGENCY MEDICAL PROBLEMS. THIS LEGISLATION WAS ENACTED BECAUSE CONGRESS WAS CONCERNED ABOUT THE INCREASING NUMBER OF REPORTS THAT HOSPITAL EMERGENCY DEPARTMENTS WERE REFUSING TO ACCEPT OR TREAT PATIENTS WITH EMERGENCY MEDICAL CONDITIONS IF THE PATIENT DID NOT

HAVE MEANS TO PAY FOR TREATMENT. THERE WAS ALSO CONGRESSIONAL CONCERN THAT PEOPLE WITH MEDICAL EMERGENCIES WERE NOT BEING TREATED APPROPRIATELY OR WERE NOT STABILIZED BEFORE BEING TRANSFERRED TO OTHER HOSPITALS.

SECTION 9121 OF COBRA AMENDED THE LAW TO REQUIRE MEDICARE PARTICIPATING HOSPITALS WITH EMERGENCY DEPARTMENTS, AS A CONDITION OF THEIR MEDICARE PROVIDER AGREEMENT, TO PROVIDE, UPON REQUEST AND WITHIN THE HOSPITAL'S CAPABILITIES:

o APPROPRIATE MEDICAL SCREENING EXAMINATIONS AND TREATMENTS FOR ALL INDIVIDUALS WITH EMERGENCY MEDICAL CONDITIONS AND ALL WOMEN IN ACTIVE LABOR; AND

o A MEDICALLY APPROPRIATE TRANSFER TO ANOTHER FACILITY WHEN INDICATED, UNLESS PATIENTS OR THEIR LEGAL REPRESENTATIVE REFUSE TREATMENT OR TRANSFER.

THE ENHANCED ENFORCEMENT MECHANISMS AUTHORIZED BY COBRA PROTECT INDIVIDUALS WHO SEEK TREATMENT IN HOSPITAL EMERGENCY ROOMS AND ENSURE THAT THEY ARE MEDICALLY EVALUATED, PROPERLY TREATED AND IF

APPROPRIATE, PROPERLY TRANSFERRED. FAILURE OF A HOSPITAL TO TREAT OR STABILIZE A MEDICAL EMERGENCY WITHIN THE HOSPITAL'S CAPABILITIES WILL JEOPARDIZE A HOSPITAL'S STATUS AS A MEDICARE APPROVED INSTITUTION.

COBRA PROVIDES FOR THREE RESPONSES THAT THE DEPARTMENT CAN TAKE IF A HOSPITAL FAILS TO COMPLY WITH THE STATUTORY REQUIREMENTS.

THE FOLLOWING BRIEFLY SUMMARIZES THE RESPONSIBILITIES OF THE LAW.

- WE MAY TERMINATE OR SUSPEND THE HOSPITAL AGREEMENT, THUS ENDING OR INTERRUPTING THE HOSPITAL'S PARTICIPATION IN THE MEDICARE PROGRAM;
- CIVIL MONETARY PENALTIES OF UP TO $25,000 FOR EACH CASE OF DUMPING MAY BE ASSESSED AGAINST THE HOSPITAL AND PHYSICIAN; AND
- CIVIL ACTIONS MAY BE INITIATED BY THE PATIENT OR ANOTHER HOSPITAL UP TO TWO YEARS AFTER THE VIOLATION.

THE CONGRESS PROVIDED FOR EITHER TERMINATION OR SUSPENSION OF A MEDICARE PROVIDER AGREEMENT OF A HOSPITAL THAT EITHER KNOWINGLY AND WILLFULLY OR NEGLIGENTLY VIOLATED THE LAW. UNDER THE TERMINATION PROCEDURES THE HOSPITAL HAS AN OPPORTUNITY TO TAKE CORRECTIVE ACTION IMMEDIATELY, AND REMEDY THE PROBLEMS THAT CAUSE THE VIOLATION, THUS ASSURING THAT QUALITY IS MAINTAINED AND

ACCESS TO HEALTH CARE IS NOT INTERRUPTED.

THE LEGISLATION ALSO PROVIDES FOR THE SUSPENSION OF THE HOSPITAL'S MEDICARE PROVIDER AGREEMENT. SUSPENSIONS CAN BECOME EFFECTIVE IMMEDIATELY AFTER REASONABLE NOTICE HAS BEEN MADE TO THE HOSPITAL.

A SIGNIFICANT DIFFERENCE BETWEEN TERMINATION AND SUSPENSION IS THAT THE FORMER ENCOURAGES THE HOSPITAL TO IMMEDIATELY CORRECT ITS BEHAVIOR AND AVOID LOSS OF ITS PROVIDER AGREEMENT. THEREFORE, TERMINATION IS ORIENTED TOWARD COMPLIANCE. BY CONTRAST, SUSPENSION COULD BE USED AS A COMPLIANCE TOOL AS WELL AS A SANCTION DESIGNED TO ASSURE THAT A HOSPITAL IS PENALIZED FOR ITS PAST ACTS. BOTH OF THESE TOOLS ARE INTENDED TO PROTECT PATIENTS FROM THE POSSIBILITY OF BEING DUMPED AND TO DETER UNLAWFUL DUMPING IN THE FUTURE.

THE DEPARTMENT ALSO HAS AUTHORITY TO IMPOSE A CIVIL MONEY PENALTY (CMP) OF UP TO $25,000 PER INSTANCE WHERE A HOSPITAL HAS KNOWINGLY "DUMPED" ANY INDIVIDUAL. A CMP MAY BE IMPOSED IN LIEU OF TERMINATION OR SUSPENSION, OR IN ADDITION TO THESE REMEDIES. MORE IMPORTANTLY, A CMP MAY BE IMPOSED NOT ONLY ON THE HOSPITAL BUT ON THE RESPONSIBLE PHYSICIAN OR PHYSICIANS.

FURTHERMORE, INDIVIDUALS WHO HAVE BEEN INJURED AS A RESULT OF A HOSPITAL'S DUMPING MAY INSTITUTE A SUIT TO RECOVER MONETARY

DAMAGES AND ALSO FOR EQUITABLE RELIEF. SIMILARLY, A HOSPITAL THAT HAS RECEIVED SUCH PATIENTS MAY INSTITUTE A SUIT AGAINST THE OFFENDING HOSPITAL SEEKING TO RECOVER THE COSTS OF TREATMENT AS WELL AS INJUNCTIVE RELIEF.

UNDER A SEPARATE STATUTORY PROVISION, THE DEPARTMENT ALSO HAS THE RESPONSIBILITY TO ASSURE THAT THOSE HOSPITALS THAT HAVE RECEIVED LOANS UNDER THE HILL-BURTON PROGRAM PROVIDE EMERGENCY MEDICAL CARE TO ALL INDIVIDUALS IN THEIR COMMUNITY.

UNDER THIS PROGRAM, HILL-BURTON ASSISTED FACILITIES ARE REQUIRED TO MAKE THEIR SERVICES AVAILABLE TO ALL PERSONS RESIDING (AND, FOR TITLE XVI FACILITIES, WORKING) IN THE FACILITY'S SERVICE AREA WITHOUT REGARD TO RACE, COLOR, NATIONAL ORIGIN, CREED, OR ANY OTHER GROUND UNRELATED TO THE NEED FOR OR AVAILABILITY OF THE SERVICE.

THE HILL-BURTON PROGRAM PROVIDED FEDERAL FUNDS FOR THE CONSTRUCTION OR MODERNIZATION OF PUBLIC AND PRIVATE NON-PROFIT HEALTH CARE FACILITIES. THOUSANDS OF HOSPITALS, PUBLIC HEALTH CENTERS, NURSING HOMES, AND REHABILITATION FACILITIES WERE BUILT ACROSS THE COUNTRY USING FUNDS FROM THIS PROGRAM.

THE COMMUNITY SERVICE REQUIREMENT UNDER HILL-BURTON RELATING TO THE PROVISION OF EMERGENCY SERVICES PROHIBITS A HILL-BURTON

FACILITY FROM DENYING EMERGENCY SERVICES TO ANY PERSON WHO RESIDES (OR, FOR TITLE XVI FACILITIES, WORKS) IN THE FACILITY'S SERVICE AREA BECAUSE THAT PERSON IS UNABLE TO PAY FOR SUCH EMERGENCY SERVICES. A FACILITY MAY DISCHARGE A PERSON WHO HAS RECEIVED EMERGENCY SERVICES OR IT MAY TRANSFER A PERSON TO ANOTHER FACILITY ABLE TO PROVIDE NECESSARY SERVICES. HOWEVER, UNDER HILL-BURTON A DISCHARGE OR TRANSFER IS ALLOWED ONLY WHEN APPROPRIATE MEDICAL PERSONNEL DETERMINE THAT SUCH ACTION WILL NOT SUBJECT THE PERSON'S MEDICAL CONDITION TO A SUBSTANTIAL RISK OF DETERIORATION.

ANY REVIEW OF THE PROBLEM OF PATIENT DUMPING MUST CONSIDER THE REALITIES OF THE CHANGING HEALTH CARE ENVIRONMENT. FOR EXAMPLE, IT SHOULD BE ASSUMED THAT INCREASES IN PATIENT TRANSFERS MEAN PATIENT CARE HAS DETERIORATED. WE KNOW THAT MANY PATIENTS WHO SEEK CARE IN EMERGENCY ROOMS DO NOT HAVE URGENT OR UNSTABLE MEDICAL PROBLEMS AND COULD APPROPRIATELY BE TRANSFERRED TO OTHER TREATMENT FACILITIES. COBRA CLEARLY INTENDS THE PROVISION TO APPLY TO PERSONS WHOSE CONDITIONS ARE UNSTABLE OR WHOSE HEALTH COULD BE PLACED IN JEOPARDY WITHOUT PROMPT EMERGENCY TREATMENT.

THE GOAL OF OUR POLICY IS TO ENSURE THAT EMERGENCY ROOMS PROVIDE APPROPRIATE EVALUATION OR TREATMENT OF PATIENTS WITH MEDICAL EMERGENCIES OR TRANSFER SUCH PATIENTS ONLY AFTER THEY ARE MEDICALLY STABLE.

WE WOULD LIKE TO EMPHASIZE THAT WE ARE COMMITTED TO ASSURING ALL PATIENTS THE RIGHT TO RECEIVE PROMPT AND APPROPRIATE EMERGENCY MEDICAL SERVICES.

Mr. **Weiss**. Mr. Kusserow.

Mr. **Kusserow**. I think it would be best just to use the time to answer any questions of concern the subcommittee might have.

Mr. **Weiss**. Fine. Ms. Morton, do you have any opening comments?

Ms. **Morton**. That would be my reaction, too.

Mr. **Weiss**. OK. I am going to start by asking some questions of Dr. Roper, and then turn it over to Mr. Lightfoot at that point, and then ask questions of you, Mr. Kusserow, and Ms. Morton.

Dr. Roper, let me start with the point at which you closed your comments. We heard some compelling testimony this morning about a very serious problem. You are aware that in enacting the antidumping law, the Congress was expressing its great concern about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance, and that medically unstable patients are not being treated appropriately.

Do you agree with this assessment of Congress' concern about this issue, and did you support enactment of the legislation last year?

Dr. **Roper**. Did I personally, or did the Department?

Mr. **Weiss**. The Department.

Dr. **Roper**. I wasn't in the Department, but if I can get to the heart of your question, if patients are turned away inappropriately, that is a problem and I think the Congress took a wise step and we are vigorously enforcing this provision.

Mr. **Weiss**. Right. The amendment, as you have indicated, was adopted in April 1986 and was given an effective date of August 1986 so that there would be time for the adoption of regulations. Yet, as late as today, not even proposed regulations have been published; isn't that correct?

Dr. **Roper**. That is correct, yes, sir.

Mr. **Weiss**. Has even a notice of proposed rulemaking been published?

Dr. **Roper**. That is proposed regulations; no, sir.

Mr. **Weiss**. Then let me ask you, when does the Department plan to publish a notice of proposed rulemaking on this issue?

Dr. **Roper**. As soon as possible, Mr. Chairman. Let me comment in two fashions. One, the fact that the Congress gave us a law that could be implemented without regulations, we are pleased for and we have proceeded to implement it without the regulations. I would just reemphasize the point I made in my opening statement.

We take seriously the need to write regulations and are well along in that process, but to give you what I assume must sound like a bureaucratic response, COBRA and OBRA gave us a total of 83 regulations to write.

The fact that we are sorting out what we see to be problems in the wording of the statute is one of the things that has slowed down the process. Dick Kusserow is, I think, better able to describe for you the problems that we face. But we are pressing ahead with writing the regulations, nonetheless.

Mr. **Weiss**. You sent us two drafts of proposed regulations, one dated May 1986, and the other dated April 1987, both of which very closely track the statute itself. Those regulations could not have been that difficult to draft, so, again, why such a long delay?

Dr. ROPER. Just the process of getting concurrence first within my agency, and then the Department, generally, on some matters that have some confusion attached to them in the statute.

But, also, again I cite the regulatory burden that we face; the large number of regs. We knew that there were some provisions that the Congress gave us in OBRA and COBRA that could not be implemented absent regulations. We put those at the top of our list.

This one was self-implementing.

Mr. WEISS. The first interim operating instructions for enforcing the COBRA antidumping amendment were issued in a June 4, 1987, memo to HCFA regional administrators. That was 10 months after the COBRA amendment became effective, right?

Dr. ROPER. Yes, but we had had extensive discussions with our regional administrators in December 1986, explaining to them how they ought to handle complaints that came forward to them. June 4 is when we formally put it in writing and sent it to the regions.

Mr. WEISS. Those interim instructions place the primary investigative responsibility on State licensing and certification agencies, don't they?

Dr. ROPER. Yes, that is, the State agencies are the prime investigators of our quality and enforcement activities, generally, for compliance.

Mr. WEISS. Are the State agencies reimbursed for their investigatory work?

Dr. ROPER. Yes.

Mr. WEISS. At what rate; do you know?

Dr. ROPER. I would be glad to find out for you.

Mr. WEISS. Our information is that it is 75 percent of cost. You have no reason to disagree with that, do you?

Dr. ROPER. I will be glad to supply the figures for the record, sir.

[The information follows:]

For complaint surveys during FY 1987, the HCFA pays the total cost at a national average hourly rate of $32.13. This figure represents hourly salary/fringe benefits travel/per diem and secretarial/administrative overhead, which varies from State to State.

Mr. WEISS. OK. Only a small percentage of hospitals in the United States are not accredited by the Joint Commission on Accreditation of Hospitals, or the American Osteopathic Association. The State agencies survey these hospitals for licensure and certification purposes, and to assess eligibility for Medicare and Medicaid. Most of the surveys, I understand, are paper reviews rather than onsite investigations. Is that your understanding, also?

Dr. ROPER. I think so, yes, sir.

Mr. WEISS. Right. And patient dumping violations should be investigated onsite, right?

Dr. ROPER. They are all investigated onsite.

Mr. WEISS. How can you expect the State agencies to have the expertise or even the personnel to adequately investigate dumping complaints, when they are basically a paper review apparatus?

Dr. ROPER. Let me go back and correct. The State agencies do many paper reviews, but they are fully capable of doing onsite reviews where necessary. And, clearly, as we have instructed our regions, a case of this sort is one where it would need immediate, expedited, onsite review; no question about it.

Mr. **Weiss**. Have you reviewed the capacity of the various State agencies to do onsite investigations, and the extent to which they do undertake onsite investigations?

Dr. **Roper**. No, sir. I have not. Our staff does that continually, though.

Mr. **Weiss**. I would appreciate your submitting to us for the record the review that you have of the capacity of the State licensing and certification agencies to do onsite inspections?

[The information follows:]

The State Survey agencies are required by HCFA to employ qualified professionals to perform surveys of facilities participating in the Medicare and Medicaid programs. These individuals are required to complete Federal training programs to ensure that they can reliably ascertain whether Federal participation requirements are met. In addition to these certification surveys, the States respond to complaints relative to the health and safety of patients, including the "dumping" of patients.

HCFA's regional offices employ a cadre of qualified health professionals that are responsible for monitoring the performance of State agency personnel. The regional office staff routinely conduct Federal monitoring surveys of health care providers to ensure that the State surveyors apply the requirements consistent with Federal protocols. Also, Federal surveyors may conduct additional surveys based on complaints received from the public, ombudsman programs and other sources. This would include surveys conducted to investigate allegations regarding "dumping" cases.

In addition, HCFA has instructed Peer Review Organizations to provide medical expertise to support either State Agencies or HCFA staff if additional medical personnel are needed to evaluate a case. We believe that the full range of resources that can be brought to bear on any complaint are more than adequate to ensure a full and proper investigation.

Dr. ROPER. Sure. If I could, Mr. Chairman, make a general point in response to your question. While we do have, we believe, adequate capacity to investigate these, and we will make certain we have whatever the capacity is necessary, it is our view that the prime moving force of this piece of legislation is a deterrent effect, and it is our belief that the vast number of hospitals in America do not want to do dumping. We are carefully pointing out to them what the law is, and urging them to be vigorous in instructing their emergency room staff and other staff as to what the law is so that there won't be any of these cases.

My point simply is that we place immediate first-line focus on making sure these things don't happen, but of course, we need to have the resources to follow up and investigate those cases that do happen.

Mr. WEISS. The fact is that the Congress adopted this legislation because the problem of dumping has been growing year by year by year; isn't that correct?

Dr. ROPER. There have been growing allegations, yes, sir. I believe it was the Congress' intention that the prime focus be a deterrent, a message——

Mr. WEISS. Indeed, but in order to do that you have to acknowledge that there is a growing problem; and you have to make sure that the capacity of the agencies to undertake the proper investigation so that they can serve as a deterrent effect is there; isn't that——

Dr. ROPER. True.

Mr. WEISS. Right. Dr. Kellermann had testified earlier—I don't know if you heard any of his testimony——

Dr. ROPER. No, sir. I missed it.

Mr. WEISS. Dr. Kellermann is the medical director of emergency services at the Memphis Regional Medical Center. He testified earlier that the Methodist Hospital in Tennessee dumped a young man named Terry Takewell, who died the next day—which, literally was a case of dumping. They had taken Mr. Takewell from the emergency room, placed him out in the parking lot. He crawled under a tree, which is where he was found by the friends who had taken him to the hospital to begin with, and he died the following day.

Dr. Kellermann testified that the State agency reviewed the actions of the hospital and found that they had not violated State law. He said that in Tennessee, the board which supervises the agency responsible for surveying a hospital for a potential dumping violation is controlled by persons directly related to private hospitals and nursing homes.

My question is, would you expect that a State agency under the control of a board such as the one in Tennessee would be able to conduct an adequate, impartial investigation and render an impartial judgment regarding the private hospital for violating this law?

Dr. ROPER. Mr. Chairman, I am not personally acquainted, but I will be glad to look into it with State law and the provisions of this board in the State. I would presume that the citizens of Tennessee would constitute a board that would be able to carry out their given duties.

[The information follows:]

The two State agencies are separate and distinct. One agency reports to the Federal Government for purposes of the survey; the other to the Governor of the State.

The Tennessee Department of Health and Environment's Division of Health Care Facilities is responsible for State licensing and Medicare and Medicaid certification. There is a program director and staff for each of these areas and a director in charge of the division. The licensure staff performs licensure surveys and makes recommendations to the Board of Licensure. The Medicare/Medicaid certification staff conducts surveys of Medicare and Medicaid facilities and submits its findings to the HCFA RO.

The Tennessee Board of Licensure is appointed by the Governor and is composed of 13 members of the health care industry as follows:

- Public hospital affiliations
    - Pharmacist
    - Dentist
    - Administrator

- Private hospital affiliations
    - Doctor of osteopathy
    - Three administrators
    - Surgeon

- Nursing home/home health agency affiliations
    - Owner of a private nursing home
    - President of a private nursing home
    - Administrator of a home health agency

- Two consumer representatives

Mr. **Weiss**. That may be a very naive assumption, Dr. Roper, because the testimony that we had was that the problem that the public hospitals face is trying to ward off dumping. The very board they have to take their complaints to is controlled or, for the most part, composed of people who are involved with the boards of the private hospitals who are engaged in the transferring, dumping, itself.

I asked the question to hark back to the question as to whether the State agencies are really appropriate agencies to do this kind of investigative work.

Dr. **Roper**. In general, I believe strongly that the State agencies are. I worked as the head of an urban county health department and assistant head of a State health department, and know what those agencies are all about. I believe strongly that the State agencies are closer to the problem and the best vehicle for us to depend on at the first order.

We need to have a look behind, a followup process at the Federal level. As to the situation in Tennessee, I would be glad to look into the allegations made by the doctor from Memphis. We take that seriously.

Mr. **Weiss**. I wish you would, but I wish that you would look beyond this and at it as an example of the kinds of concerns that people have expressed about the utilization of the State boards which may be dominated by the very people who are being investigated.

We have the second bell at this point for a quorum call. We are going to take a break, hopefully for no more than 10 minutes.

[Whereupon, a short break was taken.]

Mr. **Weiss**. The subcommittee is back in session.

I think we will now have probably about an hour before we get another interruption.

Dr. Roper, the interim instructions direct State agencies to conduct a survey to investigate a complaint within five working days. The survey, the memo explains, must investigate emergency services and medical staff.

Is that the extent of the guidance offered? Does it indicate additionally what questions to ask, whom to interview, and what records to examine?

Dr. **Roper**. No, sir. The document gives general instructions that the State agency is to investigate the case and these are trained professionals that do whatever is necessary to get the full facts of the case.

Mr. **Weiss**. So that aside from stating that the survey must investigate emergency services and medical staff, the memo does not tell the State agency anything at all about how to conduct the survey; is that right?

Dr. **Roper**. It tells them to use their professional training.

Mr. **Weiss**. Isn't evidence of dumping likely to be found by surveying the receiving hospital, as well as the transferring hospital?

Dr. **Roper**. By surveying, you mean talking to people at the receiving hospital?

Mr. **Weiss**. Right.

Dr. **Roper**. Sure, yes, sir.

Mr. Weiss. Do the interim instructions suggest that the State agency survey the receiving hospital?

Dr. Roper. It doesn't mention it, but I would, again, depend on the professionalism of the investigators to do that. It is an important part of many investigations.

Most of the complaints that we have received, 70 percent to date, have come from the receiving hospital, and so they would be not only an important part of the investigation, they were the initiator of the whole process.

Mr. Weiss. But there is nothing in the memo that suggests that both hospitals be surveyed; is that right?

Dr. Roper. That is right.

Mr. Weiss. OK. What has happened to the cases filed before the interim instructions were issued last month?

Dr. Roper. We had received 35 cases, and I can go down those in detail, if you would wish. I believe we provided that information to you.

Mr. Weiss. Let's leave it at that at this point. We have the detail of that and it will be entered into the record.

[The information follows:]

[See appendix for cases as of October 9, 1987.]

LOG OF SECTION 1867 CASES

Region	Date Complaint Received	Name of Hospital	Section of COBRA Alleged Noncompliant	In Progress	In Compliance	Out of Compliance
III	01/16/87	Mary Washington Fredericksburg, VA	Treatment and transfer for active labor	X		
IV	04/27/87	Methodist, Somerville, TN	Stabilizing treatment, transfer	X		
	12/04/87	Jennie Stuart Hopkinsville, KY	Stabilizing treatment, transfer	X		
	01/08/87	Marymount, London, KY	Stabilizing treatment		X	
	01/27/87	George County/Mobile Lucedale, MS	Treatment, transfer for active labor		X	
	02/24/87	Goodlark, Dickson, TN	Stabilizing treatment		X	
	04/08/87	Jackson-Madison, Jackson, TN	Stabilizing treatment	X		
	04/01/87	Methodist Evangelical Louisville, KY	Treatment, transfer	X		
VI	01/05/87	Humana, Clear Lake, TX	Stablizing treatment, transfer	X		
	01/06/87	Dermot-Chicot Dermot, TX	Screening, treatment, transfer active labor	X		
	04/08/87	South Plains Amherst, TX	Treatment, transfer	X		
	05/05/87	Fannin County, Bonham, TX	Treatment, transfer	X		
	05/05/87	Lillian Sonora, TX	Treatment, transfer	X		
	05/05/87	Wintergarden Memorial Dilly, TX	Treatment, transfer	X		
	05/05/87	Charter Community Cleveland, TX	Treatment, transfer			X (termination underway)
	05/12/87	Trinity Memorial Trinity, TX	Treatment, transfer	X		

Region	Date Complaint Received	Name of Hospital	Section of COBRA Alleged Noncompliant	In Progress	In Compliance	Out of Compliance
	05/12/87	Riverside Corpus Christi, TX	Treatment, transfer	X		
	05/12/87	Terrell Community Terrell, TX	Treatment, transfer	X		
	05/12/87	San Saba San Saba, TX	Treatment, transfer	X		
	05/12/87	Mitchell County Colorado City, TX	Treatment, transfer	X		
	05/12/87	South Arlington Medical Center Arlington, TX	Treatment, transfer	X		
	05/27/87	Oakgrove Louisiana West Carroll Parish, LA	Treatment, transfer	X		
	05/27/87	Central Texas Medical Center Hearne, TX	Treatment, transfer	X		
	04/15/87	Trinity Memorial Trinity, TX	Treatment, transfer	X		
	12/30/86	Lewisville Medical Lewisville, TX	Treatment	X		
	01/28/87	McAllen Medical McAllen, TX	Refuse to accept indigent transfers		X	
	02/17/87	Detar, Victoria, TX	Treatment transfer for active labor	X		
	02/20/87	Alvin Community Alvin, TX	Treatment, transfer		X	
	11/21/86	HCA Valley Brownsville, TX	Treatment, transfer		X	
	04/01/87	Colonial Terrell, TX	Treatment, transfer		X	
	04/01/87	Wilson N. Jones Sherman, TX	Screening, treatment, transfer		X	
IX	03/18/87	Brookside, San Pablo, CA	Treatment, transfer			X (termination rescinded)
	04/9/87	LosMedanos Pittsburg, CA	Transfer	X		

Mr. **Weiss**. Earlier this morning, we heard some discussion of the Hill-Burton community service obligation. Do the State agencies have any experience with this Federal law, to your knowledge?

Dr. **Roper**. I would defer to the Director of the Office for Civil Rights. I am not that familiar with the Hill-Burton legislation, since my agency does not enforce that.

Mr. **Weiss**. Mr. Kusserow, do you have any information on that?

Mr. **Kusserow**. As he has pointed out, that is with the Office for Civil Rights.

Mr. **Weiss**. Ms. Morton.

Ms. **Morton**. To my knowledge, they are not that familiar with our regulations.

Mr. **Weiss**. Right. Would State agency staff, to your knowledge, Ms. Morton, be trained to identify Hill-Burton violations?

Ms. **Morton**. I am not aware of any specific training related to Hill-Burton.

Mr. **Weiss**. OK. Let's see if we can follow a complaint. An investigation is triggered, I understand, only when an HCFA regional office determines that a COBRA complaint is warranted; is that correct, Dr. Roper?

Dr. **Roper**. Complaints come to us and we investigate them. They come to us in a variety of ways, as I said, 70 percent of them have come from the receiving hospital; others have come from family members, or members of the community. A number of them have come simply because our staff read the local newspaper and learned about an incident.

Mr. **Weiss**. But it is a fact that it is only triggered at your office when an HCFA regional office determines that a COBRA complaint is warranted.

Dr. **Roper**. Yes, that is the beginning point of the process.

Mr. **Weiss**. Now complaints can also be filed with the State agency, directly; is that correct?

Dr. **Roper**. Yes, sir.

Mr. **Weiss**. Would the State agency then have the power to decide if a complaint is warranted?

Dr. **Roper**. They would have the power and the authority to begin an investigation on their own. They have the responsibility for their own citizens.

Mr. **Weiss**. Do the interim instructions set forth any guidelines for either HCFA or the Office of Inspector General, or the State agencies to determine whether a complaint is warranted or unwarranted?

Mr. **Kusserow**. I can answer one part of that, Mr. Chairman, while we are waiting. There is absolutely nothing in there for the inspector general at this time. We have no authority to act on any investigation until the regulations go into effect and the delegations come from the Secretary.

So, I will tell you that we have no guidelines for our staff, and we are not able to act at this point.

Mr. **Weiss**. It is not accurate to suggest that because the statute went into effect, that you don't need regs. For this purpose, you need regulations. Is that correct?

Dr. **Roper**. For the sanctions part of the process, yes, sir. But if I could go back and answer your question, if I remember it, it was—

does anything in our June 4 instructions tell the regional office how to handle the facts once they have gotten them? The answer is yes. It says that if the results indicate the hospital is out of compliance with one or more conditions of participation, initiate a fast-track termination of that hospital from the Medicare Program.

Mr. **Weiss**. Read it again, slowly, for me, please.

Dr. **Roper**. "If the results"—that is the results of the investigation by the State agency, and when appropriate by the peer review organization—"indicate that the hospital is out of compliance with one or more of the conditions of participation, which results in patients being dumped, that is transferred or otherwise discharged in unstable medical condition, initiate"—this is speaking to the regional office—"initiate a fast-track termination."

Mr. **Weiss**. That is in essence a conclusion. There are no guidelines as to how you arrive at that position, to make that determination.

Dr. **Roper**. This memo doesn't set forth those guidelines.

Mr. **Weiss**. Right, and doesn't set forth any criteria to be followed; is that correct?

Dr. **Roper**. Yes, but my answer is that the people in the regional offices have detailed instructions about how to judge whether or not an agency is in compliance with the conditions of participation. It is a major part of our work.

So the fact that this memo doesn't set them forth doesn't mean they don't exist.

Mr. **Weiss**. What does exist? Tell me, again, what exists?

Dr. **Roper**. "Conditions of participation" is a detailed document that explains what hospitals, in this case, have to do to be a part of the Medicare program. Our staff have detailed instructions about how to apply those conditions of participation to specific hospital situations, and therefore, judge whether or not a hospital is in compliance with the conditions of participation.

What the June 4 memo says is, "if they are not in compliance, start the termination process."

Mr. **Weiss**. That is conditions of participation in the Medicare program. Right?

Dr. **Roper**. Yes, sir.

Mr. **Weiss**. That does not relate to the COBRA legislation.

Dr. **Roper**. That is a separate requirement, yes, sir.

Mr. **Weiss**. Right. Are you saying then there are no regulations or guidelines, or criteria that are required beyond the conditions of participation in the Medicare Program? That the new legislation, the new COBRA amendment, doesn't require anything further to be spelled out as far as guidelines or criteria are concerned?

Dr. **Roper**. The regulations will entail in clear-cut fashion what is already a practice for how to handle these complaints procedurally. But the regulations will not be setting forth criteria and guidelines, if I understood your words.

Those are already on the books, so to speak.

Mr. **Weiss**. Then why is COBRA needed? I mean, if conditions of participation are that clear cut, and they exclude dumping generally, then you wouldn't need the COBRA legislation at all. Right?

Dr. **Roper**. No, sir. The COBRA legislation said, and this was reaffirmed in the Tax Reform Act in October, that in addition to the conditions of participation, will be the matter of dumping.

Mr. **Weiss**. I have been asking you about dumping, itself, and the question, again, if I can go back, is whether there are any criteria or guidelines spelled out either to HCFA or OIG, or anybody in the State agencies, to determine whether a complaint is warranted under the antidumping provisions. The answer has to be, in fact, that no, there have been no criteria or guidelines spelled out. Is that correct?

Dr. **Roper**. Yes, sir.

Mr. **Weiss**. OK. Let's turn to the draft regulations. They provide that hospitals will be subject to termination or suspension of their provider agreements if "the evidence available establishes a definite pattern of knowing, willful or negligent non-compliance." Is that correct?

Dr. **Roper**. I don't have the draft regulations in front of me, but that sounds right. Yes, sir.

Mr. **Weiss**. We take that from page 32 of the draft regulations. The regulations further provide, on pages 32 and 33, that the determination of noncompliance will be "based on such factors as the number of violations substantiated, the period of time during which the violations occurred, the seriousness of the individuals' conditions," and other factors; is that correct?

Dr. **Roper**. Again, I don't have it in front of me, but I take it that you are reading from our draft.

Mr. **Weiss**. Yes. Again, we take that quote directly from the draft regs.

Dr. **Roper**. Yes, sir.

Mr. **Weiss**. Is it correct that single, isolated instances of illegal dumping would not be enough to cause suspension or termination; that there must be a definite pattern?

Dr. **Roper**. No, sir. What we are saying is that a single case is sufficient cause for an antidumping action, but in the review by the agency, the State agency in this case, they are to evaluate, look for a pattern of noncompliance. A single violation is sufficient cause to initiate termination.

In fact, in the cases that we have handled already, some of them were because of specific, single complaints.

Mr. **Weiss**. My understanding is that that applies if there is a "flagrant violation"; isn't that correct? The draft regulations suggest a pattern—evidence establishing a definite pattern of knowing, willful or negligent noncompliance, unless you are able to demonstrate a flagrant violation, and then a single act would be sufficient. Is that correct?

Dr. **Roper**. Yes, sir. One really bad one is enough though.

Mr. **Weiss**. Is there——

Dr. **Roper**. If I could just add, Mr. Chairman, that is parallel to the way we handle quality of care cases in the peer review organization process, as well. The PRO's overlook the Medicare program and they look for patterns of inappropriate care. But again, a single dumping case, if it is bad enough, is enough to warrant action.

Mr. **Weiss**. So that nothing less than a pattern, or a particularly flagrant instance, will trigger monetary penalties; is that correct?

Dr. **Roper**. Nothing less than a problem will not lead to a penalty, you are right. If we find a problem——

Mr. **Weiss**. No, no.

Dr. **Roper** [continuing]. Either through a pattern of cases, or a single bad case, we will take action.

Mr. **Weiss**. OK. Now, doesn't the statute specify that any single instance of illegal dumping can lead to these penalties?

Dr. **Roper**. Yes, sir. That is why we are enforcing it the way we are.

Mr. **Weiss**. Well, you have gone beyond it, though. What you have said is that a single, flagrant—whatever that means—case will do it.

Mr. **Kusserow**. If I may add, Mr. Chairman, so we don't get confused. One of the problems that we are having with the regulations is the difference between termination, which is primarily a compliance mechanism, and suspension, and then CMP. The original legislation, I think, was intended to go from the more severe to the less severe.

Dr. Roper is quite correct when he is talking about the fact that when you terminate a hospital, or you suspend them, it really would require a pattern, or a real flagrant case.

But as far as the civil monetary penalty is concerned, I think it was envisioned by the Congress that a single act would not have to be gross and flagrant, but could in fact result in a monetary penalty. So it depends on what provision you are looking at in the law.

Mr. **Weiss**. I wish you would double check that. My understanding, as I read that, is that for a suspension or termination, you require a pattern of violations. For a monetary penalty, you need either a pattern or a flagrant violation.

For suspension you could not use a flagrant violation standard, a single flagrant act. Right? For that you need a pattern and then for a monetary penalty, it is not enough that you have a violation of the antidumping statute, but that you need a flagrant violation.

Mr. **Kusserow**. De facto, you are absolutely right because the standard of proof that you have, under the CMP, is that you knew or knowingly, rather than what is traditional under the civil monetary penalty standard, which knew or had reason to know, which is a negligence standard.

So the end result of that is quite as you stated. It requires it to be flagrant because if you do it knowingly or with intent, then in fact it is flagrant by definition. So you are quite right. But what you are pointing out also is one of the problems we are having with the legislation.

It parallels, but is not exactly the same as, the terminology used in other legislation that is already on the books.

Mr. **Weiss**. Who decides if a case is a flagrant violation?

Mr. **Kusserow**. We have that in the statute; it becomes flagrant, almost by definition, when you say they have done it knowingly. In other words, with intent; that is flagrant by definition.

If it stands on the books that way, that will in fact be the definition.

Mr. **Weiss**. Dr. Roper, do you agree with that?

Dr. **Roper**. Yes, sir.

Mr. **Weiss**. How many patient dumping complaints has HCFA received?

Dr. **Roper**. Forty.

Mr. **Weiss**. We have 34. How recent is the 40?

Dr. **Roper**. Forty is the count as of this morning.

Mr. **Weiss**. Of those, our information was that out of the 34, 23 were filed in region 6, the Dallas office. Was that correct?

Dr. **Roper**. Yes, sir. The more recent ones——

Mr. **Weiss**. How many of the 40 were filed from the Dallas office, do you know?

Dr. **Roper**. I would be glad to count. Can you bear with me for a moment?

Mr. **Weiss**. Sure.

Dr. **Roper**. Twenty-two of the forty are from the Dallas region.

[The following information was subsequently provided:]

The total number of cases of alleged dumping violations filed in the Dallas Region was, in fact, 23.

Mr. **Weiss**. We counted 23 out of the 34 that you submitted to us a couple of weeks ago. Why have there been so many complaints from that single region, would you know? Do you have any idea?

Dr. **Roper**. Why the number in this specific region, I don't have an answer for you.

Mr. **Weiss**. The testimony that we had this morning suggested that because of the special concern that the administrator of the Parkland Hospital in Dallas has shown in the dumping area——

Dr. **Roper**. Excuse me, sir. The State of Texas has shown special concern—they have passed their own legislation.

Mr. **Weiss**. They passed that legislation to a great extent, I gather, because of the administrator, and because there was a large amount of media attention, both local and national, on the dumping cases in Texas. As a result, people were aware of the COBRA amendment and filed complaints.

Would you draw the same conclusion?

Dr. **Roper**. The same conclusion?

Mr. **Weiss**. That the reason that there were so many complaints filed in region VI, that is in the Dallas, TX, area, is because people seemed to be aware, the public attention focused——

Dr. **Roper**. I think that is a reasonable assumption, yes, sir.

Mr. **Weiss**. If this number of dumping incidents has been identified in a single region, 22 or 23, would you assume that there must be many more than the 34 that we had a couple of weeks ago, or the 40 that we now have nationwide that could fall under COBRA?

Dr. **Roper**. There must be more. There are some unreported cases, I am sure. Yes, sir.

Mr. **Weiss**. Right. Will there be a requirement in the regulations that you are considering now, that a notice be posted in the hospital emergency rooms, informing patients of their rights under the COBRA amendment?

Dr. **Roper**. That is one of the things we are studying right now, Mr. Chairman. It may well be that that is something we cannot do through regulation; it may require specific statutory authority to post a notice. Our legal counsel is reviewing that right now.

Mr. Weiss. What are your plans for informing people about the law?

Dr. Roper. First of all to communicate this in whatever forums we can, specifically to the hospital industry. I have written to the National Association of Public Hospitals and asked them to be helpful in identifying cases that come to their attention. The public hospitals are the likely recipients of dumped cases. I have also written to the American Hospital Association and the Federation of American Health Care Systems. I think occasions like this hearing that you are holding today will inform the public of this important provision of law.

Mr. Weiss. But how about at the point of contact? Would you have any thoughts as to how you could possibly make sure that there will be a better opportunity for people who are in the situation themselves, to be aware of what their rights are under the law?

Dr. Roper. The inspector general reminds me that he is doing a study of that subject. I would like to let him talk. I would just say that we want people to be fully informed of all aspects of the Medicare law, but I think we ought to think carefully about what we would say to people, how to communicate an appropriate message.

The idea of a posted notice I would have to think carefully about before giving an opinion.

Mr. Weiss. One of those suggestions that was made by some of the medical people on the earlier panel was that perhaps having a certification requirement by the transferring physician, which would include the statement that he or she has advised the patient of all of the rights under the COBRA amendment would be appropriate, or if you had a statement by the patient or the patient's guardian or close person who is with the patient, if the patient is not able to certify that they have been so notified, might be a way of doing that.

That would at least provide for, if not the actual transferring of the information, somebody having to state that they have provided the information, or that they have been provided the information.

Dr. Roper. I would, again, want to give that some thought. As a practicing physician, having worked in emergency rooms, myself, what we are talking about is how to make sure people get the care that they need.

My reticence in seconding your suggestion about a certification is——

Mr. Weiss. Not my suggestion; the suggestion of doctors who are familiar with this particular work.

Dr. Roper. I stand corrected. But the reason I want to think about that some more is that it has the tendency to put it in very legal terms. We have people on the firing line trying to render care in a doctor-patient relationship, or whatever, and that may have the tendency to polarize——

Mr. Weiss. If you put it in the guise or context of informed consent so that people know what is happening to them.

Dr. Roper. I understand the point.

Mr. Weiss. Your draft testimony states that you have "recommended that two hospitals be terminated from Medicare for failure to meet the new emergency medical care condition of participation."

Would you explain the new condition of participation and what happened in the two cases recommended for termination?

Dr. Roper. Explain the condition of participation?

Mr. Weiss. Yes, the language that was used in your draft testimony was that you have recommended that two hospitals be terminated from Medicare for failure to meet the new emergency medical conditions of participation.

I want to know what you meant by that and what happened in the two cases that were recommended for termination?

Dr. Roper. Mr. Chairman, we published revised conditions of participation for hospitals in the Medicare program about a year ago and there was a provision in that dealing with emergency services, how emergency departments of hospitals were to be organized and staff, et cetera. I would be glad to provide a copy of that to you.

[The information follows:]

§ 482.55 Condition of participation: Emergency services.

The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice.

(a) *Standard: Organization and direction.* If emergency services are provided at the hospital—

(1) The services must be organized under the direction of a qualified member of the medical staff.

(2) The services must be integrated with other departments of the hospital;

(3) The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff.

(b) *Standard: Personnel.* (1) The emergency services must be supervised by a qualified member of the medical staff.

(2) There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility.

§ 482.56 Condition of participation: Rehabilitation services.

If the hospital provides rehabilitation, physical therapy, occupational therapy, audiology, or speech pathology services, the services must be organized and staffed to ensure the health and safety of patients.

(a) *Standard: Organization and staffing.* The organization of the service must be appropriate to the scope of the services offered.

(1) The director of the services must have the necessary knowledge, experience, and capabilities to properly supervise and administer the services.

(2) Physical therapy, occupational therapy, or speech therapy, or audiology services, if provided, must be provided by staff who meet the qualifications specified by the medical staff, consistent with State law.

(b) *Standard: Delivery of services.* Services must be furnished in accordance with a written plan of treatment. Services must be given in accordance with orders of practitioners who are authorized by the medical staff to order the services, and the orders must be incorporated in the patient's record.

Mr. **Weiss**. I would appreciate that. What happened in the two cases; do you know?

Dr. **Roper**. There are eight cases altogether.

Mr. **Weiss**. You recommended eight cases for termination?

Dr. **Roper**. Yes, sir.

Mr. **Weiss**. What happened to them?

Dr. **Roper**. Ultimately, five of the cases came back to us before the termination was effective with corrective plans of action that were acceptable to us. We rescinded the termination in those five cases and are continuing vigorous oversight.

Three of the eight cases are still in progress at the moment.

Mr. **Weiss**. Have they in fact been terminated?

Dr. **Roper**. The three?

Mr. **Weiss**. Yes.

Dr. **Roper**. No, sir. We are in the 23-day period right now. If I could explain the way the process works. Once our regional office is satisfied that a case warrants the beginning of the termination process, we issue a formal notice of termination action to the hospital. The clock begins and there is a 23-working-day period before the termination can be effective. If we do not rescind our action during that period of time, it will become effective and the hospital is kicked out of the Medicare program.

In five of the cases, the hospitals came forward to us with corrective action plans that were satisfactory to us.

In the three remaining cases, we are presently within that 23-day window and we have not yet come to the end of it.

Mr. **Weiss**. Is one of the hospitals with the corrective action plan Brookside?

Dr. **Roper**. Yes, sir.

Mr. **Weiss**. In any of these cases, were any of them referred to the Office of the Inspector General for other possible penalties?

Dr. **Roper**. Yes, sir; all eight have been.

Mr. **Weiss**. All eight. Now, Dr. Roper, we heard testimony this morning from Mrs. Hill who reported the case of the young man who was placed outside in the parking lot, and Dr. Kellermann, on the same case.

Dr. **Roper**. Yes, sir.

Mr. **Weiss**. On October 27, 1986, JONAH, a community organization in west Tennessee filed a complaint with the inspector general. The complaint alleged that the Methodist Hospital violated the antidumping law in the case of Terry Takewell. When did the IG or HCFA respond to this complaint?

Mr. **Kusserow**. We referred the complaint over to the Health Care Financing Administration. The way the system is designed is that the primary concern in any case is to ensure that patients going to a hospital as of this moment are in fact going to get the promised care, and that the hospital is in compliance.

So the first step is for the Health Care Financing Administration to make that determination. If they are out of compliance, then they terminate them.

At the conclusion of that process, if they feel that there should be an investigation of the past acts, or penalties, then they refer it for investigation by the inspector general.

In the case of Somerville, I believe that as yet they have not found it out of compliance and therefore there is no retrospective investigation planned.

Mr. Weiss. HCFA has not found it out of compliance?

Mr. Kusserow. No, sir.

Mr. Weiss. Do you know whether and when HCFA responded to the complaint? You, Mr. Kusserow, said that you forwarded it on to HCFA, right. So that that was your way of dealing with it.

Mr. Kusserow. On any complaint by any source that we would get, the first step would be to go to the Health Care Financing Administration to protect patients currently going to that hospital.

Mr. Weiss. OK. Would you expect HCFA to acknowledge the receipt of that complaint by them to the organization or people who forwarded the complaint in the first instance? Did you notify the people who filed the complaint?

Dr. Roper. If I understand the nature of your question, Mr. Chairman, it is our desire to let everybody know what we are doing in a case. My understanding of this one was that the process began with a newspaper article that presented the facts of this case in Tennessee and that this is what led to the investigation. That is why we did not go back and inform an individual.

Clearly, it is our intention when there are specific individual complainants to make sure they know where we are in the process. If we dropped the ball on this one, that is not what we intended to do.

Mr. Weiss. Well, you had a formal complaint that was filed with the Office of Inspector General hotline from this organization, Just Organized Neighborhood Area Headquarters (JONAH); that is dated October 27, 1986.

Mr. Kusserow, you have indicated you transferred that over to HCFA, that that is the appropriate channel to take. But our records indicate that there was nothing further until April 27, 1987, when there was a form response sent to the organization's president by HCFA.

That is October 27 to April 27, which is a delay of some 6 months, and then my question is whether there has been any further communication from HCFA or the Office of the Inspector General, or the State agency to the people who filed the complaint?

It is my information that there has not been. Do you have any further information?

Mr. Kusserow. No; but we certainly can go back to our files and come back for the record on that.

Mr. Weiss. But I am not really interested in having my records complete. What I am really interested in is finding out why in fact it would take 6 months before the organization was sent a letter of acknowledgment that their complaint had been received, and since then nothing. Silence.

Don't you think that people who file complaints ought to be kept apprised as to what is happening?

Mr. Kusserow. Sure.

Mr. Weiss. My question is, what is going on? Why the silence?

Dr. Roper. On this case, I don't know, sir, but like Mr. Kusserow said, we will go back and look at it. It is not our plan, intention or anything else to keep people in the dark.

[The information follows:]

On September 25, 1986, a Tennessee State licensure staff person noted a newspaper article on the alleged dumping of a patient named Terry Takewell, from Methodist Hospital, Somerville, Tennessee. The State licensure staff reviewed the incident and decided that this alleged dumping case warranted investigation under the State's dumping provisions. The State investigation was performed on October 7, 1986 and October 16, 1986. On 4/27/87, the Tennessee licensing staff notified the HCFA regional office of the case. The HCFA regional office reviewed the investigation procedures and findings of the State licensure staff and determined that the investigation was sufficient to evaluate compliance with Medicare requirements. Therefore, the regional office did not authorize the State Medicare certification staff to conduct another investigation of the incident.

The State Board of Licensure heard the case on May 28-30, 1987. The Board found the hospital in compliance (voting 8 to 3) with State minimum standards. The Board is composed of 13 representatives of the health care industry appointed by the Governor and chaired by Dr. Alsup of the Tennessee Department of Health. Two of the 13 board members were not present to vote on the Methodist Hospital, Somerville case.

HCFA found the hospital in compliance based on the findings of the State licensure investigation and referred the case to the OIG on 7/13/87. No complainant was informed of the findings of the investigation because the complaint originated from a newspaper article.

[See testimony of Zettie Mae Hill, pp. 21-24.]

Mr. Weiss. You have regulations in place—does anybody have regs in place, or rules of the house or anything which says within *x* period of time you have to let people know what is going on?

Dr. Roper. I imagine that is going to be part of our regulations, sir.

Mr. Weiss. But in the meanwhile, supposing this was a different nature of a complaint. Supposing this was not filed under the antidumping law. Supposing it was filed under Hill-Burton. Supposing it was filed under Medicare provision of services.

There must be something in place which says when a complaint is received, within *x* number of days we notify, or acknowledge the receipt of complaint, and then within *x* number of days hence we tell them what is going on.

Dr. Roper. You are so right. There should be. Good business practice dictates doing that.

Mr. Weiss. But if you don't know that, then who should?

Dr. Roper. The people who are involved in the operating of the complaint process out in the regions. I will be looking into that and I will be glad to provide you a response.

We believe an important part of our work is timely response to the public.

Mr. Weiss. In your interim operating instructions, the State agency is directed to "conduct at least a limited survey to investigate the complaint within 5 working days."

Dr. Roper. Yes, sir.

Mr. Weiss. Does it seem unusual to you that a 5-day limit is imposed on the State agency when, in this particular instance that we have cited, it took 182 days for a mere acknowledgment to be mailed from HCFA.

Shouldn't your own agency be subject to the same 5-day rule or requirement?

Dr. Roper. We have to respond in a timely fashion, sir. Clearly, we should.

Mr. Weiss. I assume that if there were regulations in effect, implementing the COBRA amendment, that this kind of excessive delay would not be happening, or at least wouldn't be as likely that it would happen. Do you agree with that?

Dr. Roper. We ought not to be that slow in any event.

Mr. Weiss. OK. A Tennessee lawyer who filed a similar complaint with the Office of Inspector General hotline also had no results, and wrote a letter to Congressman Pete Stark's staff person. It says, "The two administrative complaints sent to the so-called 'OIG Hotline' might just as well have been put in a bottle and tossed into the Tennessee River for all the response they have generated."

[The information follows:]

LEGAL SERVICES OF MIDDLE TENNESSEE, INC.
800 Stahlman Building
211 Union Street, Nashville, Tennessee 37201 (615) 244-6610

⑦

April 20, 1987

Brian Biles, M.D., M.P.H.
Office of Rep. Pete Stark
U.S. House of Representatives
Washington, D.C. 20515

Re: COBRA Medicare "Anti-Dumping" Enforcement

Dear Brian:

I understand that Congressman Stark is interested in following up on last year's Medicare anti-dumping amendments to find out how well the new law is being enforced. If experience in Tennessee is any indication, the answer is that the new law is not being implemented at all by the Department of Health and Human Services.

I enclose two complaints made to the HHS Office of Inspector General seeking to invoke administrative enforcement of the new law. As you can see, both of these cases are extremely serious, and the Methodist Hospital case resulted in death. There has been no written acknowledgment or any activity regarding either of these cases.

After these complaints were filed with the OIG, I received a copy of the HCFA transmittal authorizing the states to investigate complaints under the new law. (A copy of the transmittal is enclosed.) However, I have checked with the Tennessee state agency, and they have never received any information from either HCFA or OIG regarding the two complaints enclosed. As it happens, the state agency is independently investigating the Methodist Hospital case and has filed detailed charges before the state licensing board. (A copy of the notice of charges detailing the egregious circumstances of the case is also enclosed.) The case before the state regulatory board is scheduled for a three-day contested hearing next week, April 28-30. However, the state of course lacks the defunding and other enforcement tools granted to the Secretary under § 9121 of COBRA. Thus, regardless of the findings made by the state licensing board, Methodist Hospital will continue to receive full Medicare funding.

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Brian Biles, M.D., M.P.H.
Office of Rep. Pete Stark
U.S. House of Representatives
April 20, 1987
page 2

Patient dumping is an extremely serious problem in Tennessee. For your information, I enclose a copy of a description of a state regulatory hearing in which the Medical Director of the Emergency Department of The Regional Medical Center ("The Med"), the state's largest public hospital, submitted the bracelets of 286 patients dumped on his facility by area hospitals over a period of a few months. As the records compiled by The Med documented, many of these patients were grossly medically unstable when they arrived at the public hospital's emergency department.

Because of these problems, it was widely hoped in Tennessee that the COBRA protections would provide some much-needed relief. However, it would appear that, as far as HHS is concerned the anti-dumping provisions of COBRA are a dead letter. The two administrative complaints sent to the so-called "OIG Hotline" might just as well have been put in a bottle and tossed into the Tennessee River for all the response they have generated.

If you need further information, please feel free to contact me.

Sincerely yours,

Gordon Bonnyman

GGB:cj

Mr. Weiss. Now, can HCFA and the OIG overcome this kind of——

Mr. Kusserow. Is that the same case?

Mr. Weiss. Different case; same area; same State.

Mr. Kusserow. I am not aware of that at all.

Mr. Weiss. This complaint was filed against Goodlark Hospital in Dickson, TN, and the lawyer was Gordon Bonnyman.

Mr. Kusserow. Be glad to look into the facts, sir. I just don't know that one.

Mr. Weiss. That was sent on February 4, 1987. He says that he has heard nothing at all.

Mr. Kusserow. If it was sent to our office and we haven't responded, I would like to have a copy of that and I will check and see. I am not aware of that.

Mr. Weiss. OK. We will get you a copy of it.

Your list of complaints that you have submitted to us shows that an investigation has been done and Goodlark Hospital is in compliance with COBRA.

Dr. Roper. Yes, sir. That is right.

Mr. Weiss. The two don't square.

Dr. Roper. Sounds like we didn't answer the mail. As I have told you, it is our intention to do that in a timely fashion.

Mr. Weiss. But it is even worse than that because, not only haven't you responded, but you have indicated that in fact Goodlark is in compliance. Now, they may or may not be in compliance.

Dr. Roper. They are in compliance as a result of our investigation. Not sending the mail back didn't mean——

Mr. Weiss. How would the person who filed the complaint know that if you don't notify them of it so that they could either agree or take exception to your finding? I would assume that they would have been reached out to just to see whether in fact they have anything to add to their complaint.

Mr. Kusserow. Where was it mailed to? I have checked the records and I am not aware of that complaint. Was it sent to——

Mr. Weiss. OIG hotline, Office of Inspector General, Department of Health and Human Services, P.O. Box 17303, Baltimore, MD.

Mr. Kusserow. OK. I will check that. At the conclusion of the hearing we will go back and go through them. I think we have had somewhere in the neighborhood of 70,000 or 80,000 complaints come through that hotline since I have been inspector general, and this may have fallen through the cracks.

It is not our policy to have that happen. If we have a case here, let me check it out and see if there is something broken that needs to be fixed.

Mr. Weiss. But it didn't fall between the cracks because it went on to HCFA and it appears in the log of determinations of complaints and determinations.

Mr. Kusserow. That showed up in there? Did that come from a separate source; was it mailed from more than one source, or did it come from us?

Mr. Weiss. All I can tell you is that the date, complaint received, is 2-24-87. This was dated 2-4-87.

Mr. Kusserow. And the complainant said that is the only number they sent it to?

Mr. Weiss. Listen, I have no way of knowing that. All that I am saying to you——

Mr. Kusserow. I feel somewhat relieved in the fact that at least it was handled in a timely fashion. Your concern, as I understand it, is that somewhere along the line in the bureaucratic process, there wasn't an acknowledgment of that letter. Is that correct? Not that it wasn't acted on in a timely fashion, but that there was not an acknowledgment of the complaint to the original complainant. Is that correct?

Mr. Weiss. I am talking about what is apparently a very serious complaint. It talks about a client who is a diabetic with a 12-year history of serious heart disease. He and his family live in Dickson, TN, about 40 miles from Nashville, and he has been treated both as an out-patient and as an in-patient at Goodlark Hospital on several occasions over the years.

He has also received treatment, including open heart surgery. November 1986 he was hospitalized for 6 days at St. Thomas Hospital for a bloodclotting problem. Following his discharge, he was followed on an out-patient basis by a doctor at Goodlark.

On Thursday, December 11, 1986, the patient was taken to the emergency room at Goodlark Hospital at around 5 a.m. He was experiencing chest pains and was ill. His heart was monitored for about 2 hours and he was sent home still wearing the monitors.

The family members took him back to the hospital at 7:15 the following day. The monitors were removed and he was sent home. Later that morning, his physician called his house and said that he needed to be hospitalized. He was instructed to come to the doctor's office in the hospital building at 1 that afternoon. At 1 that afternoon, members of the family took him to Dr. Bell's office.

His heart was monitored for about an hour in the doctor's office. Dr. Bell then called in the wife, handed her the originals of the papers, which are attached to this letter as attachments, and told her that the patient needed to be admitted to intensive care for monitoring of his heart.

The patient's wife took the papers to the admitting office where she was interviewed by a young blonde, female clerk. Meanwhile, the patient was in a wheelchair outside the admitting office waiting for the admitting process to be completed.

Part way through the interview, another person came out and interjected that the patient had no insurance coverage. She apparently overheard the conversation between the patient's wife and one of the interviewers.

It is a fairly typical kind of a case. I am not talking about paperwork. I am talking about a dumping situation——

Dr. Roper. That was investigated in a timely fashion.

Mr. Weiss. Again, it just seems to me that where you have a complaint of that kind coming to you, that there ought to be some system in place where you don't just make a determination that things are going swell and dispose of it and never let the complainant know that in fact——

Mr. Kusserow. As I understand it, the concern is that as opposed to the three alternatives, that it was properly acknowledged, or that it was properly handled in a timely fashion, or that the outcome was desirable or undesirable—you are saying that where we fouled up here is in the fact that we didn't acknowledge it; not that we were not timely in the process, or there wasn't a proper determination process made.

Mr. **Weiss**. It is bad enough when people don't know that the law exists. But when you have somebody who, because of appropriate counsel, finds out that there is a law that they can take advantage of, and they make a complaint and if, in fact, that complaint is not acknowledged, and they are never told about the disposition, especially when the disposition is negative to their complaint, it seems to me that the message that you are sending is not the kind of message that you want to send.

It seems to me that what you want to be doing is letting complainants know that even if it turns out that you don't find their complaint to be actionable, that at least you have sufficient concern for their having made the complaint, that you keep them apprised as to what is happening.

Mr. **Kusserow**. That is a fair comment on your part, and, yes, sir, we ought to do that.

Mr. **Weiss**. Well, I am glad we agree. As of Friday, July 17, 1987, the Tennessee State health agencies had never received either of these complaints; neither the one against Methodist Hospital, filed on behalf of Terry Takewell, nor the one against Goodlark Hospital. So apparently the breakdown is not just with the complainant, but also with the State health agency.

Dr. **Roper**. They had not received what, sir?

Mr. **Weiss**. They had not received either of these complaints from your office.

Dr. **Roper**. They investigated the complaint, sir, at our request.

Mr. **Weiss**. The information that we have is that in fact that is not the case. That however the "in-compliance" determination was made, it seems not to have been made on the basis of the investigation by the State health agency because they said, as of July 17, they had not received either of these complaints from HCFA.

Dr. **Roper**. That is curious. I would have to check into it.

Mr. **Weiss**. Would you check into it?

Dr. **Roper**. I know in the case of the Somerville instance that the State health agency specifically was involved in doing the investigation. After all, that is how we heard about it. You said the earlier witness testified about his question about the composition of the board at the State level that presided over that investigation.

Mr. **Weiss**. It is a hospital review board. Yes.

Dr. **Roper**. Yes, sir. That is the State.

Mr. **Weiss**. This is the State agency, itself.

Anyhow, I would appreciate your looking into it and letting us know why the confusion.

Dr. **Roper**. Sure.

[The information follows:]

The Office of the Inspector General initially received the complaint against the Goodlark Hospital. The original complaint, dated 2/04/87, was sent to the OIG Hotline from Mr. Clyde Lowe's lawyer. The complaint alleged that Mr. Lowe was denied admission to the Goodlark Hospital on 12/12/86 because he had used up his Medicare and Medicaid days. The complaint also alleged that at the time Mr. Lowe was denied admission, he was experiencing chest pain, arm numbness and choking. The next day, Mr. Lowe's family took him to St. Thomas Hospital in Nashville where he was admitted.

Mr. Lowe's complaint was referred to the HCFA regional office by the OIG on 2/24/87. HCFA authorized the Tennessee State Agency to conduct a complaint investigation. The survey was conducted on 3/3/87 and after reviewing the survey findings, the regional office, on 4/1/87, determined that Goodlark Hospital was in compliance and that a dumping violation had not occurred. The complainant was not informed of the findings because this determination was made prior to the June 4, 1987 memorandum specifying the procedures for notifying complainants of the survey findings. Our procedures now specify that complainants are notified both when the HCFA RO receives a complaint and after the investigation is complete. The model letter acknowledging the complaint informs the complainant of his or her right to pursue independent civil action and includes a copy of the statute.

Goodlark Hospital, Dickson, Tennessee — Chronology

December 11, 1986

Mr. Clyde W. Lowe went to the emergency room of Goodlark Hospital because he had chest pain. He was monitored for 2 hours and went home with a portable diagnostic monitor.

December 12, 1986

Mr. Lowe returned to the hospital to return the monitor and went home. Later that day Mr. Lowe returned to the hospital and his physician, Dr. Walter Bell, read the monitor findings and decided that Mr. Lowe could be safely treated on an outpatient basis.

December 13, 1986

Mr. Lowe went to St. Thomas Hospital in Nashville and was admitted and then discharged on December 18.

December 26-29, 1986

Mr. Lowe went to Goodlark Hospital with chest pain and was given a diagnostic workup, including chest x-ray, was admitted December 27 and discharged December 29, 1986.

February 4, 1987

Mr. Gordon Bonnyman, attorney for Mr. Clyde Lowe, wrote a complaint to the OIG Hotline, Baltimore. The letter alleges that Mr. Lowe was denied admission on December 12, 1986, because he had used up his Medicare and Medicaid days, even though he was experiencing chest pain, arm numbness and choking.

February 24, 1987

The HCFA RO received the complaint from the OIG.

March 3, 1987

At the HCFA RO's request, the State agency investigated the complaint. The survey found an admission policy stating that the facility admits patients regardless of race, color, creed, national origin, sex, religion or ability to pay. The insurance coordinator stated that she had told Mrs. Lowe that Mr. Lowe's physician, Dr. Walter Bell, had stated that Mr. Lowe could be safely treated as an outpatient. Dr. Bell signed a statement to the effect that he had rescinded an admission order because he felt Mr. Lowe could be safely treated as an outpatient. Dr. Bell further stated that he was confident that if he had wanted to admit Mr. Lowe that the hospital would have admitted him. Dr. Bell's statement refers to his conversation with the physician who treated Mr. Lowe at St. Thomas Hospital and states that they both agreed that Mr. Lowe's problem was primarily psychological, that his condition was unchanged and that his medications should also continue unchanged. Dr. Bell describes Mr. Lowe as "a chronic cardiac cripple" weighing between 280-290 pounds and totally noncompliant with diet, exercise and medication programs. The survey found that Mr. Lowe subsequently received service from Goodlark Hospital. Hospital billing records reflected three other patients who were recently admitted and unable to pay.

April 1, 1987

The HCFA RO determined that Goodlark was in compliance and that a dumping violation had not occurred.

Mr. **Weiss**. Dr. Roper, on May 15, 1987, the OCR director wrote you to request that appropriate staff from HCFA and OCR meet "in order to discuss the cooperative efforts we may undertake" with regard to the COBRA antidumping amendment.

The law was adopted in April 1986, more than a year earlier. Why had no such meeting taken place prior to this request?

Dr. **Roper**. We have cordial relations with the Office for Civil Rights, and we have referred all the cases to them prior to the meeting. I presume the meeting was called because Director Morton felt it was useful to get together.

Mr. **Weiss**. This is in regard to the COBRA antidumping amendment. That office is going to have to be playing a role. Wouldn't you think that there ought to have been a meeting earlier than that?

Dr. **Roper**. The fact that there hadn't been a meeting hasn't impeded the process. We had referred all the complaints to them and we have had a good working relationship with them.

Mr. **Weiss**. But I don't think it is just the complaints. I think it is a question of how to handle the antidumping amendment as far as regulations are concerned, as far as rules and guidelines and so on.

Dr. **Roper**. They don't have authority under the COBRA antidumping law. What we refer the cases to them for is for their separate investigation as to whether the Hill-Burton law was violated in this case. We have given them all 40 of the complaints as they have come to us.

Mr. **Weiss**. You sent a document to us that states that "formal instructions" to be issued by HCFA will "require referral to OCR of all dumping allegations." A second document states that OCR will be "notified of complaints and provided with evidence HCFA collected in support of its actions."

Dr. **Roper**. Yes, sir.

Mr. **Weiss**. Has HCFA notified OCR of all of these cases?

Dr. **Roper**. Yes.

Mr. **Weiss**. Is that done automatically?

Dr. **Roper**. Yes, sir.

Mr. **Weiss**. That is part of your procedure?

Dr. **Roper**. Early on in the process we send them on to them.

Mr. **Weiss**. OK. Let me at this point yield to Mr. Lightfoot.

Mr. **Lightfoot**. Thank you, Mr. Chairman. Dr. Roper, over the last several years there have been a number of major changes made in the Medicare program and, if I remember correctly, you said that you had to author something like 83 regulations.

Dr. **Roper**. Yes, sir. That is out of last year's legislation.

Mr. **Lightfoot**. Given the fact that you haven't yet issued your final regulations on the antidumping provision, do you feel in any way that that has impaired your ability to implement that provision of the law, or not?

Dr. **Roper**. In general, no, sir, but there are some provisions that specifically relate to the inspector general's power to take penalty action.

As Mr. Kusserow can tell you, the regs will take care of that, unless legislative changes are warranted and we raise for consideration—or, he raises for your consideration those changes.

The long winded answer. My direct point is that we are enforcing the COBRA antidumping legislation now.

Mr. LIGHTFOOT. From some of the discussion earlier today, black and white isn't nearly as evident as all the gray area that is out there. Do you feel that when the regulations are issued it will become more of a black and white issue or not?

Dr. ROPER. No, sir. I think we have gray—medical judgments, which is what most of this is. Having, as I said, worked in an emergency room, and made those judgments myself, it is going to be difficult. We are calling on people to make difficult judgments under public scrutiny, and that is always going to be difficult. We are always going to have the gray area.

One of the key questions in all of this is whether a patient is adequately stabilized from a medical viewpoint, stabilized enough to be transferred. Again, I worked in a large urban teaching hospital, and took patients in transfer.

I am a pediatrician, and took patients in transfer from remote rural hospitals—newborn babies who were in difficult straits. It is always a question of judgment whether that baby is better off staying in that remote hospital because they are too unstable to transfer, or whether it is better to send him on to the other hospital because of the better resources that are available there.

Those kind of judgment calls are going to be made continually.

Mr. LIGHTFOOT. Maybe this isn't a proper question at this point in time, but it is something that has bothered me for some time over a number of issues, from the PRO's and the DRG's, right into this particular situation, and that is, as mentioned earlier this morning briefly, that the clinical judgment of the physician is being downgraded by all types of regulations, as we go along.

I happen to be one that believes a physician with 10 or 15 years of experience ought to know something about trying to get me well if I am sick. We tend to find doctors in a position of practicing defensive medicine in a lot of different areas. As a trained physician, and also as the head of one of these regulatory agencies, first, is that a valid assessment, and, second, what are you trying to do to get around that particular area if you perceive this as a problem?

Dr. ROPER. Oh, I sure do. Clearly, the judgment of physicians, the autonomy of physicians to make independent judgments is being eroded in many cases; appropriately so in some cases; in some cases inappropriately. But physicians are under the gun, so to speak.

They are clearly being told how to practice medicine. My colleagues call that cookbook medicine and that is not a very comfortable circumstance to be in. But the Congress has specifically said, in this instance, we want something done—or, more properly, we want something not to happen.

That calls for our regulatory agency to build in a set of processes to make sure that those bad things don't happen. But it raises a whole set of troubling questions for physicians who are trying their best to practice medicine.

If I could elaborate my point further; I try, in my statements, Mr. Congressman, to stress my abiding faith in the vast majority of doctors and hospitals and their professional judgments and their desire to practice good medicine. If we lose our ability to trust them, we don't have enough police—Mr. Kusserow doesn't have enough police to make sure that everybody does the right thing as we judge that to be the case.

We have to have a fine balance between enough police action to make sure that the cases of bad practices are routed out and punished. We definitely need to do that, while at the same time trusting most of the people to do the right thing.

Mr. LIGHTFOOT. From your perspective, how have the hospitals reacted to the COBRA requirements? Are most of them complying with it in your opinion?

Dr. ROPER. Yes, sir. I think they are.

Mr. LIGHTFOOT. We heard some testimony this morning indicating that there might be a lack of knowledge on the part of some institutions of knowing that these regulations exist. Do you perceive that as any kind of a problem?

Dr. ROPER. I think that is a problem, and I have over the last couple of months written letters to the major hospital associations, and to the State hospital associations. I have asked the regions to do that; to make sure that they inform their members about this. We need to get the word out.

Mr. LIGHTFOOT. The Lone Star State of Texas has been favorably mentioned several times today in respect to its relatively strong antidumping law that they have. Yet, as we look at your reports, it appears that Texas is where a large number of complaints are being filed. What is the correlation? Are people in Texas aware that there is a State law, and they are trying to protect their rights under that law, or—what do you see as the reason that we have that correlation between the two?

Dr. ROPER. Texas is a big State, first of all.

Mr. LIGHTFOOT. 999 miles from one point to the other.

Dr. ROPER. But, sure, you are right. The fact that there have been some cases given wide notoriety in Texas, through the news media, has certainly led to other people lodging complaints in similar circumstances. That is a part of the public education effort.

Mr. LIGHTFOOT. Do they have—I am not familiar with the law, other than what we have heard today. Do they have a better reporting system, or not, as compared——

Dr. ROPER. It is the same system as is in place in the rest of the country.

Mr. LIGHTFOOT. Sometimes when you do get a better system, you tend to find things which were ignored in the past because people didn't realize there was a place to go with their problems.

In response to a comment made earlier, that with the passage of COBRA they hadn't seen much effect take place in terms of reporting, or people being dumped out of hospitals. In that respect, is the statute clear enough, do you think, to let you put together the strong regulations that you apparently are going to need? Is the language OK? Does it need to be stronger, weaker?

Dr. ROPER. The intent of the legislation is clear cut, and that is why, as the chairman indicated, our early drafts of the regulations track the language of the statute.

There are some provisions primarily relating to the enforcement powers given to our several agencies that are unclear, and I would defer to Mr. Kusserow to elaborate on that.

Mr. **Kusserow**. The biggest problem, I think, Mr. Lightfoot, is the fact that on the enforcement side, termination is put at the top because that is where you want to be sure that any hospital that is not providing the promised treatment is in fact taken out of the system.

The conjunctive that links it to the next enforcement mechanism, suspension, is "or," not "and/or." So the first problem is that if you indeed move aggressively to terminate, you can automatically terminate now but you are not able to suspend later for past misdeeds.

We have been struggling with that, with our attorneys, ad nauseam, trying to find a way in which we could certainly get to what Congress originally intended. We are convinced that it is meant to be an alternative. If the object of the action is to bring them in compliance, termination is it.

But once termination, or once the compliance issue is set aside, and you want to look back and find out whether there are past misdeeds, then you should have the ability to suspend if you find that the pattern of activity was so egregious as to warrant it, as well as to be able to provide monetary penalties, if that be appropriate.

As it reads now, and we are convinced by attorneys that this is, in fact, what the law says, it means if you terminate then you cannot suspend. If you suspend, you cannot terminate.

That turns into a catch-22 situation because for us to go ahead and build a case to suspend a hospital, we have to afford all kinds of additional due process, which takes a long period of time. This would mean that patients could be at risk during that period of time. You can't do that.

If you move to terminate, then you can't suspend. So we are going around and around in circles. The end result is that the major enforcement mechanism in the law, that is being able to suspend where the pattern of practice has been so bad, is not there. We are not going to get to it.

We think that we are going to have to seek legislative clarification on that point. In fact, I believe Mr. Stark was here this morning alluding to the fact that they are trying to study this point. We brought it to their attention and said that it is one of several points in the law that creates problems.

Another problem mentioned earlier is the fact that as far as the civil monetary penalty is concerned, they put the standard at "knowingly." You have to show that they knowingly did violate the law, rather than go for the other standard—know or had reason to know—which now exists for civil monetary penalty legislation elsewhere in our department's programs. They "know or had reason to know" incorporates gross negligence, as well as specific intent.

We think that Congress would want to clarify this, and make it consistent across the board.

We also have the civil monetary penalty level at $25,000 per count. But what you are talking about are not simply green-eyeshade auditors or gumshoe investigators going in and looking at a hospital. You are really looking at patient files. You really need qualified medical records administrative people, as well as physicians, to be able to make a case. So it is going to be a very expensive process to develop a case and then to prosecute and successfully litigate. So the end result is, as we have looked at it, is that the Government is going to spend more in developing the case than would the offending party being penalized at $25,000, if in fact we sustain the Government's case. We don't believe Congress intended that. Our recommendation is to increase the penalty to $50,000. This is another point that we have brought to their attention.

So what we have, in creating this legislation, is that Congress had borrowed from existing law. Congress really extended this antidumping provision to apply to all beneficiaries of hospital services, not just Medicare beneficiaries. But in many cases that we have been reviewing and which we have reviewed here today, you are really talking about cases where we are not going into with delivery problems and in heavy labor. By and large, it almost excludes the majority of the Medicare beneficiaries.

What the law says is that the condition of participations in Medicare should extend to all patients, not just Medicare patients. But by building on preexisting law, what they have done, is incorporate those procedures and we are trying to reconcile that with the COBRA version.

The same holds true when they extended the penalty provision. They used the term of art "suspension" and they used "civil monetary penalty." There is a history on that and there are inconsistencies there.

So, we are convinced, after struggling for months on this issue with the attorneys, that we are going to have to ask Congress to help us straighten this thing out.

Mr. LIGHTFOOT. Spending too much time on paper and not enough time on people.

Mr. KUSSEROW. The frustration for me is that I want to get at some of these hospitals and, not having this clarification means that our best weapon available, suspension, for taking on hospitals that have been acting in an inappropriate fashion, is by definition denied us.

That frustrates me and we need that weapon and we need to bring that to your attention because the whole issue we have been talking about here for the last couple of hours is how do you build good deterrents into the program? You can't do it by issuing traffic tickets to hospitals, when a $25,000 penalty comes out of petty cash.

What you really ought to be able to do is be able to suspend for a period of time, depending upon how egregious their actions have been in the past, and we need that. We don't have that now. We have struggled to find a way in which we could construct the rulemaking. Dr. Roper and I are convinced the rulemaking cannot be the vehicle to do it. We are going to have to ask for legislative assistance on that.

So we are frustrated in the fact that we can't really put the full sanction side of that law into full effect.

We can protect the beneficiaries, today, with the termination procedure, making hospitals come into compliance, but going back and making cases against hospitals that behave in improper fashion, we are handcuffed. I don't think that was what was originally intended by the Congress.

So we are going to have to go back to the Congress and ask for help on this.

Mr. LIGHTFOOT. Is the reporting system to identify the patients that are being mistreated adequate?

Mr. KUSSEROW. I don't know. Chairman Weiss has certainly introduced some doubts in my mind as to whether we are fully efficient in the process. Certainly, when things come over our hotline which relate to program operations, one where we do not directly investigate ourselves, but defer to another agency to acknowledge, I think that both Dr. Roper and I are convinced that we probably need to go back and revisit how to do that, especially in this important area and see if there is something we can do to tighten the process.

If it is a case where I would investigate it directly, then we handle it differently. But, again, part of it is the fact of not being able to get past the full implementation; getting the full effect of what the law intended out there on the street. It is frustrating because we would like to go after some of these folks, but putting the full force of the law into effect is very, very difficult in the present circumstances.

Mr. LIGHTFOOT. If you could write the new law, what would it say?

Mr. KUSSEROW. I will tell you one thing, I would increase the amount of the civil monetary penalty provision; I would double it and make it $50,000 per count, so that at least the Government wouldn't spend more in making the case than the wrongdoer paying.

I think the second thing we could do is add, or change that connective, and make it "and/or" rather than just "or" so that if indeed we make a case and there is a pattern of abuse by a hospital, and they are dumping people out, that we indeed, among other things can take action to suspend them from the program for an appropriate period of time.

Of course, we would afford full due process through administrative trial and so forth, but at least, that penalty is available to us, which is not the case now.

I think also—I would have to say that the level of proof, the burden of proof, would have to change to be more consistent with other administrative penalties, and that is you don't put "knowingly" as if you are talking about beyond a shadow of a doubt, criminal prosecution. You are talking about a hospital that may in fact also operate negligently, or grossly negligent, and we should be able to go against those people and have them say—well, we may have done wrong, but we didn't intend to do wrong. It should not be an excuse for the action.

If you take that into consideration when determining a penalty, it certainly should not be as severe a penalty as somebody who with malice or forethought goes ahead and does something, but it certainly should be something that they could be held accountable for.

In the final analysis, Congress has been very, very active. This last Congress was indeed very active, for Dr. Roper and for us. We have had 13 new laws that were created that the inspector general is going to enforce, all the way from the HMO enforcement provision, to physician incentive plans, right across the board to antidumping, and all of this was done without any consideration being given to providing adequate resources to deal with it.

Going back to these kinds of cases we are talking about, these antidumping cases. We need qualified health professionals to examine these cases and to build these cases, not necessarily somebody who is an auditor or an investigator.

One of the things I am going to have to do is enhance the physicians on our staff and other health professionals on our staff to enable us to use that resource to make these kinds of cases. Otherwise they are not going to hold up with the administrative due process that we afford somebody accused of wrongdoing.

Mr. Lightfoot. How long have you been in your position?

Mr. Kusserow. Seven years.

Mr. Lightfoot. So from the comments you made earlier, you are getting 10,000 to 12,000 complaints a year?

Mr. Kusserow. Yes, sir.

Mr. Lightfoot. Are they all kinds of complaints?

Mr. Kusserow. All kinds of cases, going all the way across. We have a pretty good record as far as increasing the aggressiveness. In 1981, in the criminal prosecutions of people who would defraud our programs, we had 165 convictions. Last year, we had 1,055, which is roughly one-third more than the FBI produced in the entire Federal Government during the same period of time.

From the administrative sanctioning perspective, 39 health providers in the Medicare, Medicaid, and child maternal health programs, in 1981, to over 400 last year, roughly an 1100-percent increase. In dollar savings in the Department, we went from $166 million to $5.3 billion, all during a period of time wherein our staff resources have been going down.

So I think we are being more efficient. We certainly are very aggressive. If we can take some of these kinks out of this legislation, I guarantee you that those hospitals out there will know what the meaning of deterrence is when it comes to dumping out people that should be stabilized and given proper treatment.

Mr. Lightfoot. There has to be coordination between Federal and State agencies in this whole process. Whomever wants to answer this can, but do you think that this coordination exists and, if not, what could be done to improve it?

Dr. Roper. The prime coordination of the State agencies is through my agency, HCFA, and I am satisfied that we have a good working relationship with the States. I further believe, as I said earlier, that it is important that we use the State agencies to do these investigations, not only for resource reasons, but also they are the people understanding of local conditions.

So we have a good relationship with the States; not perfect, but good.

Mr. Lightfoot. The people that are in a position to be dumped are people at the bottom end of the income ladder, or no income at all. Mr. Green testified this morning about the gentleman—I don't know whether you heard his testimony or not—who needed emergency hospital treatment. There was one hospital he had heard of that gave good treatment, but they were a little reluctant to take people.

He called legal services to find out what his friend's rights were. Are the potential victims of dumping adequately informed of their rights and, if not, what could be done to improve that situation?

Mr. **Kusserow.** One of the things I alluded to earlier, Mr. Lightfoot, is the fact that we have commenced a study to try to understand what is going on in the hospital community subsequent to the passing of the COBRA antidumping provisions.

We are trying to understand what kind of educational efforts exist to inform hospitals and their physicians, as well as patients, about what's going on, and how successful it is. We are really concerned about—and this, again, goes back to my investigative hat—what kind of recordkeeping procedures are taking place at the hospitals, what kind of statistics are available. Are there trends and problem indicators that we can build off of to be able to go after these things proactively.

In other words, just not sit back and wait until somebody picks up the phone and calls in or writes a letter saying they think they have a problem, but to allow us to identify in advance hospitals which might not be complying with the spirit and intent of the antidumping provisions in the law.

We are also looking at what kind of protocols exist on the transfer of emergency patients. For example, normally the protocol is for doctor-to-doctor communication. The doctor in the one hospital talking to a doctor in another hospital.

We are interested in knowing how you can keep track of that, and one of the things that we are really interested in is the fact that in about half the cases that we have been able to survey so far, the doctor-to-doctor conversations are in fact recorded, which leaves a record that would allow us to come in after the fact and see whether a hospital is acting out of compliance and, if they are, how egregious.

I think that is very important.

We are also very much interested in what is going on with cooperative hospital community efforts to address the problem of antidumping. What are the dynamics that are taking place out there?

We have a study that should give us some good insight and help us be guided on what it is that we can do to more effectively educate hospitals, physicians and hospitals, and the patients going into those hospitals.

We have that on a fast track and I would hope to have that done either late summer or early fall. As soon as it comes out, we will make it available to the committee.

Mr. **Lightfoot.** This is a hypothetical question to some degree, but basically I think the answer is not hypothetical. We had a few TV cameras here today and the story will get out that we had this hearing.

It is quite likely that Congresswoman Pelosi or Chairman Weiss or I will get a phone call from somebody who will say, you know my cousin went to the hospital and got dumped out, but they didn't report it to anybody. We call you up and say that there is an allegation that individuals were dumped out of hospital X in city Y; what do you do at that point?

Dr. **Roper.** If you call me, what I will do is call the HCFA regional office that has responsibility for that State and say—we have a complaint; investigate it. They will follow the procedures they have in place to investigate it, beginning with asking the relevant State agency for that State to initiate a fast-track investigation within 5 working days, and all the things we have been over already.

If you have any of those, call me.

Mr. LIGHTFOOT. As of 10 minutes ago, we didn't.

I think that pretty well covers the questions I had, Mr. Chairman.

Mr. WEISS. Thank you, very much. Ms. Pelosi.

Ms. PELOSI. Mr. Chairman, I have no questions. I just wanted to thank you for bringing the problem of patient dumping to the subcommittee today. I would be very interested in the followup that you receive on the Methodist Hospital case because it seems such an appalling abuse.

Again, thank you for calling it to our attention. My questions have already been asked.

Mr. WEISS. Thank you for your participation.

I have a few more questions. First, Dr. Roper, do you agree with the suggestions or recommendations that Mr. Kusserow outlined in response to Mr. Lightfoot's question as to how to tighten up the law to make it more workable?

Dr. ROPER. Yes, sir.

Mr. WEISS. Have you had occasion to discuss it among yourselves?

Dr. ROPER. Yes, sir.

Mr. WEISS. One of the things that Mr. Stark said was that he would welcome your coming forward—we are talking about all three of you—with suggestions or recommendations for making the law more workable. He said, and I agree with him, that Congress would react very, very quickly and very positively in that regard.

Mr. KUSSEROW. Everything that I said so far, Mr. Chairman, we have already communicated to Mr. Stark.

Mr. WEISS. When was that?

Mr. KUSSEROW. In this last week. The other thing I would add—there are a couple of other points arising from this hearing that I think would be relevant to mention.

Mr. WEISS. Please.

Mr. KUSSEROW. Congress may wish to look in terms of the effectiveness of this statute. Dr. Roper alluded to it in part, himself, when he was talking about the term "stabilize." That is not an exact term.

One of the things that you heard earlier, and also has been widely published, related to Dr. Ansell, is the fact that this represents a real problem in trying to pin down somebody when you have a term that is not exact.

Maybe what we should really try to better define is what do we mean by stabilize prior to transfer. I think that this is something that is going to cause us problems in the future.

Mr. WEISS. One of the suggestions that was made, and I don't know how much of the hearing you heard or that you were present for, was that the very concept of using the term "stabilize" may in fact not be a constructive or helpful one. It may create more problems than it solves, and that the thing to do is not to use a term such as "stabilize," but to simply require a justification on medical grounds of whatever transfer takes place.

Mr. Kusserow. I think that is a very useful suggestion. That would be very helpful. I do think that stabilize as a term is going to cause problems.

I would also, if I may, offer another observation. We have, in fact, an anticipation that we had resolved the difficulties in implementing the sanction side of this legislation. I have already come across the problem of what happens to a patient who is diverted before they actually reach the premises of the hospital. In other words, where there may be communication from the hospital to the ambulance saying—don't bring them here.

Some of the more egregious kinds of situations you can imagine are where somebody in transit, or somebody who is preparing someone for transit, is being told in advance not to come to the hospital.

This antidumping provision doesn't extend to those kind of provisions. Maybe Congress might want to look and see whether there might be merit in trying to deal with those kinds of situations, where there are advanced agreements—whether they are months in advance or whether they are in advance of them arriving at the hospital, itself.

I think that would be helpful.

Mr. Weiss. I think so, too. I think it was in that area that Mr. Stark also indicated that he would welcome suggestions coming from those of you who are working with this problem day in and day out.

Let me ask each of you, because in each case of patient dumping there may be several applicable Federal laws. There are three HHS offices that you represent and a State agency that conducts investigations and several sanctions that can be applied. Who is going to do what? Is there in fact a problem of overlapping and resultant confusion from that overlapping? I would like each of your responses to that.

Mr. Kusserow. Let me start, first, since I will be the odd dog here. I do think there is a problem there. I think that as far as the COBRA provisions are concerned, this should not represent a problem. In the Medicare-Medicaid sanction authorities, we have already worked out all the protocols, and the understanding as to when the baton passes from the Health Care Financing Administration to the inspector general. I don't think there is any problem in that arena.

The difficulty is going to be for the roughly 6,500 hospitals covered by the COBRA antidumping provisions that are under Medicare conditions of participation and who are also under Hill-Burton. Out of that universe of 6,500 hospitals, approximately 4,100 had received assistance under Hill-Burton.

So what you have is an entirely different set of authorities arising from Hill-Burton, which Ms. Morton handles. The same fact situations in most places would, in fact, apply to the Medicare antidumping provision.

This was mentioned earlier. Ms. Morton has convened conferences among the present hosts to try to see if we can work out some sort of modus vivindi, if you will, but it is something that has to be sorted out.

I do think that there are some problems in that process. But as far as the Medicare side and the State agencies and the inspector general, I do not think that that represents any kind of confusion because you are building upon an existing body of law and protocols that have already ironed out those kinds of kinks.

Mr. **Weiss.** Ms. Morton.

Ms. **Morton.** I agree with Mr. Kusserow. The potential for problems certainly is there. However, the focus for OCR is very different from that of the Office of Inspector General, as well as for HCFA.

Traditionally, individuals who are served by OCR are those who have had the most difficulty in obtaining Government services. As such, we take the approach of working within the community, working with health care officials, as well as State and local governments, to try to increase understanding of our authority, and to assist them in compliance.

Case in point, and you have alluded to this several times, involving the State of Texas. We have had a very aggressive OCR presence. It was OCR who initiated the request with Parkland Hospital to conduct the study on dumping.

With that joint effort, and increased visibility of this as an issue in that particular region, you have an increase of your COBRA complaints, you have increased awareness within the community.

In addition to that, OCR has in place a survey instrument—a Hill-Burton survey that is submitted to Hill-Burton facilities once every 3 years. This instrument provides us data which would clearly indicate potential problem areas. With the results from that instrument, then the regional offices target these facilities, and begin the process of working very closely with them.

This has been the greater emphasis in addressing the dumping issue. We have not received that many complaints, but as a result of the survey instrument that I have mentioned, we have conducted a number of compliance and project reviews.

But as I indicated, our emphasis is working with the facilities and trying to maintain health care services within the community.

Mr. **Weiss.** Dr. Roper.

Dr. **Roper.** I don't have much to add, Mr. Chairman. As far as the Medicare law, we don't have any problems. We are working fine. The Hill-Burton law I leave to the Office for Civil Rights, and as I said in my earlier statements, we give them all the complaints we get.

Mr. **Weiss.** Ms. Morton, you may remember in reading the subcommittee report, published last year, that Brookside Hospital was discussed at the hearing. OCR initiated a compliance review of Brookside because of newspaper reports of a person named Eugene Barnes who came to Brookside with severe head injuries.

He died a few hours after he was dumped by that hospital because he was uninsured. The regional office found the hospital in violation of the Hill-Burton community assurance. The matter was referred to OCR headquarters on August 16, 1985.

At least until the date of the hearing on August 6, 1986, nothing further had been done by OCR on that compliance review. Can you tell us what the current status of this case is? Was the letter finding Brookside in violation of Hill-Burton ever sent?

Ms. **Morton**. I have reviewed some of the documents related to that case. Clearly, had I been here as the OCR manager, there would have been other areas to have been closely examined. It is my understanding as of March a letter was issued by the regional manager finding Brookside in compliance thereby indicating no violation.

We are at this moment working with HCFA, and as a result of the presence by HCFA, will continue to be involved to reevaluate any additional data that is received.

Mr. **Weiss**. I am going to enter both the letter of findings of no violation and the original letter of findings in which a violation was charged into the record.

[The information follows:]

PROPOSED LOF SENT TO HR 2/6 85

(15)

CERTIFIED MAIL: P 661 505 945 Return Receipt Requested

Mr. Stuart A. Jed, Administrator
Brookside Hospital
2000 Vale Road
San Pablo, CA 94806

In reply, please refer to Docket Number 09-85-7008

Dear Mr. Jed:

On February 14, 1985, the Office for Civil Rights (OCR) of the Department of Health and Human Services (DHHS) sent you notification that OCR would conduct a compliance review of Brookside Hospital (BH) as a result of an incident that occurred involving Mr. Eugene Barnes (now deceased) and your emergency department. The legal authority for OCR's compliance review comes under Title VI of the Public Health Service Act and the Hill-Burton implementing regulation at 42 C.F.R. §124.606.

Brookside Hospital is a recipient of Federal financial assistance through DHHS as a Medicare provider (#050079). In addition, Brookside Hospital is a recipient of Title VI Hill-Burton funding in the amount of $1,833,822. The dates of the funding period are 6/69 to 6/89. OCR has the authority/responsibility for enforcing Community Service compliance.

The primary issue OCR focused on was whether Brookside Hospital fulfilled its Community Service obligations under the Emergency Services requirements of the Hill-Burton regulation at 42 C.F.R. §124.603 (a) and (b) with respect to Mr. Barnes and other patients who have had similar experiences with BH.

OCR investigators found that it is a general practice of BH to directly or indirectly inform neurosurgeons and other staff physicians on emergency call of the insurance/payor or apparent financial status of patients (i.e. whether they appear to be drug users or indigent).

OCR received evidence concerning three persons (Barnes, Littlejohn and Foster) who were taken to BH for emergency care due to head trauma. In each case, the patient was either not covered by insurance (Barnes), accepted by BH (Littlejohn) or had no apparent means to pay for services (Foster). These patients were transferred to other facilities for emergency neurosurgery. In the Littlejohn and Barnes cases, Dr. Shortz was involved directly. Evidence shows that the payor status of these patients was made known to Dr. Shortz and that Dr. Shortz refused to accept these cases. In the Barnes case, the hospital administrator offered payment by BH for the services of Dr. Shortz and he still refused to take the Barnes case. Dr. Shortz refused to be interviewed by OCR, and therefore, it cannot be conclusively determined what reasons Dr. Shortz had for refusing the Barnes and Littlejohn cases.

In the Foster case, the patient arrived at the BH emergency room with a severe head injury and no apparent ability to pay for emergency services. He was transferred to Contra Costa County Hospital (CCCH) after a cursory examination. This transfer resulted in a formal complaint by CCCH against Brookside Hospital. The substance of this complaint is that BH failed to make an adequate diagnosis and provide sufficient information to CCCH on the patient's condition prior to his transfer. Allegedly, CCCH is the county hospital that receives indigent cases not accepted by other hospitals. Foster had obvious skull bone fragments from his injury which remained undetected until CCCH examined him. This complaint was filed with the California Department of Health Services (Licensing and Certification) and is still pending.

The preponderance of the evidence shows that the payor status of emergency neurosurgery patients is a critical element regarding admission to BH and acceptance of cases by BH neurosurgeons. It was revealed to OCR investigators during on-site interviews with the Emergency Department Director and hospital administrator that neurosurgeons are informed directly or indirectly of patient payor status as a matter of practice. Dr. Shortz's refusal to respond to OCR's request for interview only serves to cast doubt whether his refusal to accept the Barnes and Littlejohn cases was for permissible reasons under the regulations. The preponderance of the evidence supports the conclusion that Dr. Shortz, and possibly other BH physicians, select emergency cases using the patient's ability to pay/method of payment as a criterion for acceptance or rejection. This practice has the effect of denying emergency services to persons based solely on their inability to pay/method of payment.

[redacted]t. Therefore, to continue to convey non-medical information to a physician about a patient's ability to pay in emergency situations prior to providing proper medical assistance is in violation of §124.603 (a) which states that a Hill-Burton facility must "provide services without discrimination on the ground of race, color, national origin, creed or any other ground unrelated to an individual's need for the service ...," and §124.603 (b) (1) which states: "a facility may not deny emergency services to any person who resides (or, in the case of facilities assisted under Title XVI of the Act, is employed) in the facility's service area on the ground that the person is unable to pay for those services."

The practice of Brookside Hospital staff conveying information directly or indirectly about payor status of patients with respect to the provision of emergency services is in violation of 42 C.F.R. §124.603 (a) and (b).

You have no more than 60 days from receipt of this letter to: a) correct the violation; b) agree to negotiations with OCR, or c) provide OCR with a Corrective Action Plan which clearly states the timeframes and steps Brookside Hospital will take to comply with the following requirements:

1. That Brookside Hospital establish contractual arrangements with neurosurgeons and other physicians as needed to ensure emergency room services are provided regardless of the patient's race, color, or ability to pay/method of payment.

2. That these contractual arrangements with Brookside Hospital neurosurgeons and other physicians specifically prohibit any communications regarding ability to pay/method of payment (or any other information unrelated to medical need) between emergency room staff and neurosurgeons or other physicians upon notification of emergency cases.

Please be advised that any determinations of non-compliance made during this review apply only to the specific issues raised and addressed.

Under the Privacy Act and the Freedom of Information Act, it may be necessary to release this document or related documents in the file in response to inquiry.

OCR will be available to provide any technical assistance you may desire to complete the required changes. You may contact Beth DeAtley at (415) 556-3655.

Sincerely,

Hal H. Freeman
Regional Manager

LOF ISSUED ⑮
3/5/87

(415) 556-8655 (Voice)
(415) 556-8536 (TDD)

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Mr. John Friel, Chief Executive Officer
Brookside Hospital
2000 Vale Road
San Pablo, CA 94806

In reply, please refer to Docket Number 09-85-7008.

Dear Mr. Friel:

On February 14, 1985, the Office for Civil Rights (OCR) of the Department of Health and Human Services (DHHS) sent notification that OCR would conduct a compliance review of Brookside Hospital (BH). The legal authority for OCR's compliance review was Title VI of the Public Health Service Act, 42 U.S.C. § 291c (e), and the Hill-Burton implementing regulation at 42 C.F.R. § 124.601.

Brookside Hospital is a recipient of Federal financial assistance through DHHS as a Medicare provider (#050079). In addition, the hospital is a recipient of Title VI Hill-Burton funding in the amount of $1,533,822. The funding period extends from 6/69 to 6/89. OCR has the authority for enforcing Brookside Hospital's community service assurance responsibilities.

The DHHS Hill-Burton implementing regulation at 42 C.F.R. § 124.603(a) and (b) provides in pertinent part:

> (a) General (1) In order to comply with its community service assurance, a facility shall make the services provided in the facility or portion thereof constructed, modernized, or converted with Federal assistance under Title VI or XVI of the Act available to all persons residing (and, in the case of facilities assisted under Title XVI of the Act, employed) in the facility's service area without discrimination on the ground of race, color, national origin, creed, or any other ground unrelated to an individual's need for the service or the availability of the needed service in the facility.
>
> (b) Emergency Services (1) A facility may not deny emergency services to any person who resides (or, in the case of facilities assisted under Title XVI of the Act, is employed) in the facility's service area on the ground that the person is unable to pay for those services.

> (2) A facility may discharge a person that has received emergency services, or may transfer the person to another facility able to provide necessary services, when the appropriate medical personnel determine that the discharge or transfer will not subject the person to a substantial risk of deterioration in medical condition.

As part of its overall review, OCR examined the manner in which BH implemented the uncompensated services requirement of Subpart F of the regulation. In this regard, OCR was assisted by a representative from the Public Health Service (PHS) which is the agency for administrative oversight of facility implementation of Subpart F. The PHS Regional Health Administrator has already issued a letter to BH regarding its findings under this section.

With respect to OCR's findings under the issue of Brookside Hospital's requirement to provide service "without discrimination on the ground of race, color, national origin, creed, or any other ground unrelated to an individual's need for the services or the availability of the needed service in the facility" (42 C.F.R. § 124.603(a)(1)), OCR reviewed the log of admissions of patients in the hospital, patient records, and conducted interviews with hospital employees. OCR found no evidence that patients were denied treatment on any basis other than medical need.

A review of the hospital's policies and practices of requiring payment for emergency medical care revealed that the hospital encourages full payment at the time of the service. In some instances, a pre-service deposit of at least one-half of the total charge may be requested from the emergency room patient. Patients who do not have insurance are examined by the emergency room physician to ascertain if they are in a physically stable condition to safely permit them to go elsewhere for treatment. Patients will be billed $60.00 for this exam even if no medical treatment is provided. If patients are unable to pay this $60.00 examination fee, they can be offered a reduced rate of $20.00. However, if the patients do not have the $20.00 to cover even the reduced rate of the exam, they will not be denied this service. Patients without a method of payment may be directed to the hospital's credit department to establish a future means of payment. OCR found no evidence that individuals were denied emergency services because of an inability to pay.

OCR reviewed a random sample of approximately 10% of emergency admissions for a six-month period. The data indicated that, for all patients (insured, uninsured, private pay and non-paying) 78% returned home, 17.8% were admitted to the hospital, 3.8% were transferred to Contra Costa County Hospital (CCCH) and the remaining .6% were either deceased or transferred to hospitals other than CCCH. In a comparison of the data for privately insured patients with the patients who were unable to pay, the data showed that after being seen in Brookside Hospital's emergency room, 96% of the private pay patients returned home as compared with 73% of the non-paying patients. None (0%) of the private pay patients were transferred to CCCH whereas 12% of the non-paying patients were transferred to CCCH. Approximately 4% from both groups were admitted to Brookside Hospital. [redacted]

Although the statistics indicated that there was a 21% difference between private pay and non-paying patients who were returned home, the higher percentage of returnees were those who were able to pay. A 12% difference existed between non-paying patients who were transferred and private pay patients. None of the private pay patients in the sample group were transferred. Brookside Hospital's policies and procedures for the transfer of patients to other medical facilities were summarized by the hospital's Director of the Emergency Department who said, "If you would endanger a patient, you don't transfer and you shouldn't transfer the patient unless doing so would provide an increased level of care and not transferring the patient would be harmful." In any event, OCR learned that CCCH is Contra Costa County's designated Medi-Cal provider facility, and as such patients who are not able to pay for medical treatment and diagnosed to be in a medically "stable" condition can be transferred from a hospital such as Brookside Hospital to Contra Costa County Hospital for further evaluation and treatment.

One case of transfer OCR reviewed in detail involved Eugene Barnes. Mr. Barnes, an uninsured person, was brought into Brookside Hospital's emergency room with a head wound. The emergency room examination revealed that neurosurgery was required immediately. None of the hospital's on-call neurosurgeons were available to treat Mr. Barnes. The then-administrator of the hospital, Stuart Jee, offered to guarantee payment to one neurosurgeon, but this doctor declined to accept the case, purportedly because he had just come out of surgery and anticipated the need to provide further care for that patient. The neurosurgeon in question declined to be interviewed by OCR so this reason could not be confirmed. Brookside then attempted to transfer the patient to other hospitals in the area. Phone calls were made to CCCH and Highland General Hospital. Both hospitals refused to accept the transfer. San Francisco General Hospital (SFGH) did agree to accept the patient. The transfer occurred approximately four hours after Mr. Barnes was brought into the emergency room. Mr. Barnes died the next day at SFGH. In response to OCR's request for review of Mr. Barnes' medical records, a Public Health Service physician stated that the decision to transfer Mr. Barnes to SFGH was appropriate since all efforts to locate a neurosurgeon to perform a craniotomy at Brookside Hospital were unsuccessful.

It appears that Brookside Hospital did not violate the Hill-Burton community service assurance with regard to the treatment of Mr. Barnes. Mr. Barnes was evaluated and received treatment when he arrived at the emergency room. Brookside Hospital took action to locate and secure the services of a neurosurgeon for Mr. Barnes but was unable to do so. It was only after Brookside Hospital realized that it could not secure appropriate treatment for Mr. Barnes that it attempted to transfer him to another facility. The question of the appropriateness of Brookside Hospital's failure to obtain care for Mr. Barnes is a licensing and certification issue not a Hill-Burton one.

The evidence indicates that Mr. Barnes was treated at Brookside Hospital to the extent such services were available. OCR found insufficient evidence to indicate a violation of 42 C.F.R. § 124.603(b)(2) with regard to the treatment of Mr. Barnes.

As a result of this review, OCR concludes that Brookside Hospital is in compliance with Title VI of the Public Health Service Act, 42 U.S.C. § 291c (e), and the Hill-Burton implementing regulation at 42 C.F.R. § 124.601 and § 124.603(a) and (b). This determination completes the OCR review process. Please be advised that any determinations of compliance made during this review apply only to the specific issues raised and addressed.

Under the provisions of the Freedom of Information Act, as amended, 5. U.S.C. § 552, and its pertinent regulation at 45 C.F.R. Part 5, the contents of this letter and/or other information received during this review may be released upon request from the public. However, if such a request is made, we will maintain the confidentiality of information that if released, would constitute an unwarranted invasion of privacy.

If you have any questions, please feel free to call me at 556-8586.

Sincerely,

Virginia P. Apodaca
Regional Manager
Office for Civil Rights
Region IX

BROOKSIDE HOSPITAL

Region IX initiated a compliance review of Brookside Hospital, San Pablo, CA, on February 14, 1985. Brookside Hospital was selected for this review because of an incident which occured at the facility's emergency department which raised allegations in the local media that the facility did not provide appropriate services to an uninsured Black male patient who ultimately died. This compliance review was to determine the compliance status of Brookside Hospital with respect to the Emergency Service requirements of the Community Service obligation of the Hill-Burton regulation at 42 CFR Section 124.603(a) and (b).

Brookside Hospital is a district owned and operated facility in the City of San Pablo within Contra Costa County. It is a 235 bed acute care general hospital, which provides the normal range of inpatient services including two intensive care units, hospital auxiliary sevices, organized out-patient department and organized emergency department. Brookside Hospital is accredited by JCHA and is certified for participation in MediCal and Medicare, Provider #050079. The hospital is a recipient of Hill-Burton funding for the amount of $1,833,822. The dates of the funding period: June 1969 thru June 1989.

Original Findings

Region IX reviewed Brookside Hospital's admissions and emergency room policies. The hospital maintains an emergency room which provides basic emergency medical services. Brookside Hospital has a contractual arrangement for emergency room physicians which includes two (2) neurosurgeons that have full staff privileges. One other neurosurgeon has courtesy staff privileges.

In the specific case of Eugene Barnes the medical records indicate that the emergency room physician who first treated Mr. Barnes had proceeded with the intent of admitting him to the hospital. However, the patient required neurosurgery immediately. Brookside Hospital had only two neurosurgeon's with full staff privileges and one with courtesy staff privileges. None of these neurosurgeons accepted Brookside Hospital's request to operate on Mr. Barnes. The hospital has no back-up panel for neurosurgery, and does not contract with any neurosurgeons. Furthermore, the nearby hospitals were reluctant to accept the transfer. Ultimately the patient was transferred to San Francisco General Hospital where he was pronounced dead a day later.

The regions' statistical analysis of Brookside Hospital admissions, transfers and discharges indicates that patients in the private pay category are more likely to be admitted to the hospital and less likely to be transferred. The Hill-Burton regulation does not require a facility to admit a patient who is unable to pay unless the transfer would subject the patient to medical risk. However, these patients could possibly be eligible for uncompensated care under Hill-Burton.

The region concluded that the preponderance of the evidence showed that the payor status of emergency neurosurgery patients is a critical element regarding admission to Brookside Hospital and acceptance of cases by the hospital's neurosurgeons. It was revealed to OCR investigators during on-site interviews with the Emergency Department Director and hospital administrator that neurosurgeons are informed directly or indirectly of patient payor status as a matter of practice. The preponderance of the evidence supported the conclusion possibly other Brookside Hospital physicians, select emergency cases using the patient's ability to pay/method of payment as a criterion for acceptance or rejection. This practice has the effect of denying emergency services to persons based solely on their inability to pay/method of payment.

Moeover, information about the patient's ability/inability to pay is irrelevant to the specific emergency medical needs of the patient. Therefore, to continue to convey non-medical information to a physician about a patient's ability to pay in emergency situations prior to providing proper medical assistance is in violation of §124.603(a) which states that a Hill-Burton facility must "provide services without discrimination on the ground of race, color, national origin, creed or any other ground unrelated to an individual's need for the service ...," and §124.603(b)(1) which states: "a facility may not deny emergency services to any person who resides (or, in the case of facilities assisted under Title XVI of the Act, is employed) in the facility's service area on the ground that the person is unable to pay for those services."

Region IX referred the Brookside Hospital compliance review to headquarters on August 16, 1985 on the Early Warning Report (EWR). The case was lost in the mail and resubmitted on December 3, 1985. At that time a finding of non-compliance was being recommended. The case file was sent to headquarters with the approval signatures of Hal Freeman, Regional Manager; Brad Yamauchi, Civil Rights Attorney; Don Morales, Division Director; Beth DeAtley, Branch Chief; Robert Allamand, Team Leader.

Headquarters offices, OPO and OGC, reviewed the submission and concurred in a finding of non-compliance.

OGC Opinion

On August 25, 1986, George Lyon, Acting Associate General Counsel, sent a memorandum entitled "Brookside Hospital Compliance Review #09857008" to Betty Lou Dotson, Acting Deputy Director, Office of Program Operations. In the memorandum, Mr. Lyon states there is a violation due to the hospital's practice of conveying information about a payor's status prior to the provision of emergency services and, that, a patient payor status is unrelated to the need for service.

Regional Civil Rights Attorney Opinion

A memorandum dated September 12, 1986, from the Director, OCR, referred the results of the EWR review of Brookside Hospital to Region IX. Attached to this memorandum was a copy of OGC's memorandum concurring with the finding of non-compliance, and the LOW reflecting recommended changes. The region was requested to bring the LOW and LOF into conformance with the recommendations, and to resubmit the case on EWR.

Ira Pollack, Chief Civil Rights Attorney, found serious evidentiary problems in the case, and no evidence to support a finding of non-compliance against Brookside Hospital. He agrees with OGC that conveying information about a patient's payee status is a violation when that information is used to determined whether or not emergency services will be provided. However, he found no evidence to support that this was true in the case of Mr. Barnes. Mr. Pollack states there was evidence that an attempt was made by Stuart A. Jed, Hospital Administrator, to take Mr. Barnes' financial situation out of consideration. The case file record of the interview with Mr. Jed, indicates that he (Mr. Jed) offered to guarantee payment to the neurosurgeon, and that guarantee came after the neurosurgeon had already refused to accept the case, so it could not have had the effect of denying Mr. Barnes treatment on the basis of his inability to pay for services.

Mr. Pollack states the findings and recommended decision "distorts" the statement made by the Emergency Room Director in that financial information about patients is sometimes provided to physicians, but such information is provided regarding a patient's admission to the hospital and not regarding whether a patient would receive emergency room treatment.

He also states that while three incidents were referred to in the findings, only Mr. Barnes' incident was fully investigated and, therefore, based on the evidence, the hospital did all it could to secure appropriate treatment for Mr. Barnes.

Subsequently, on March 5, 1987, a compliance letter of findings rather than non-compliance was issued to Brookside Hospital by the region. The LOF was issued by different officials, regional manager and civil rights attorney, than were first involved with the case.

HCFA Brookside Hospital Case

Shortly after the issuance of the OCR LOF, HCFA moved to terminate the hospital from the Medicare program because of allegations of patient dumping. In March 1987 HCFA charged Brookside Hospital with "dumping" a 33 year old woman, who came to the hospital on March 4, 1987, and was transferred to Merrithew Memorial Hospital. Brookside officials said she was properly tested before being moved, but the doctor who examined her at the second hospital claimed that normal checks would have shown the unborn child to be in danger. The woman later gave birth to a stillborn infant. HCFA cited Brookside for major deficiencies in the administration of the emergency room.

HCFA gave Brookside a date to correct the emergency room problems or face closure. HCFA accepted Brookside's correction of the emergency room deficiencies and reinstated them in the program. The Inspector General staff, however, continues with the investigation of the allegations of dumping that HCFA sent to them. According to Region IX this case is still open. The Inspector General must prove "willful, knowing, negligent" actions on the part of Brookside Hospital in order to level civil money penalties.

BROOKSIDE HOSPITAL

Chronology of Events

February 7, 1985	Assigned to Voluntary Compliance and Outreach Division, Region IX
February 14, 1985	Investigative Plan approved
February 14, 1985	Data request letter to Brookside Hospital
February 21-28, 1985	On-site investigation
July 16, 1985	Investigative Report approved
August 16, 1985	Case referred to headquarters on EWR
December 3, 1985	Case received in headquarters (original submission was lost in mail)
December 18, 1985	Headquarters EWR work group meeting
January 17, 1986	Case referred from OPO (VCOD) to OGC for review
August 25, 1986	OGC memorandum to Acting Deputy Director, OPO, supporting Region IX's finding of non-compliance
September 12, 1986	Director, OCR, memorandum to Region IX, Regional Manager, requesting revisions to LOW and LOF as noted by OGC, and resubmission to headquarters on EWR
October 16, 1986	Ira Pollack, Chief Civil Rights Attorney, Region IX, memorandum to Virginia Apodaca stating his disagreement with headquarters findings of non-compliance
March 5, 1987	LOF of compliance to Brookside Hospital
March 1987 to Present	HCFA cites Brookside Hospital for patient dumping, and the hospital corrects the emergency room deficiencies
	The Inspector General staff continues to investigate the allegations of dumping referred to them by HCFA

Mr. Weiss. Brookside Hospital has been the site of several other dumping incidents, and yet OCR has not found Brookside in violation of any law. How do you think that is possible?

Ms. Morton. We confined that investigation to some very specific issues at that time. It is my understanding, as I mentioned earlier, that that finding was rendered as a result of the focus upon the preadmission requirements. Based upon the data that was received, reevaluated by a number of individuals, they felt that there was not a violation as related to those preadmission procedures.

Mr. Weiss. Dr. Roper, in a newspaper article about the Brookside case, a State agency official was reported as saying that COBRA cannot be enforced because of the lack of Federal regulations. If that is true, it is really tragic.

Dr. Roper. It is not true.

Mr. Weiss. If it is not true, then it is at least the perception of State agency officials in California that it is true.

Dr. Roper. Maybe it was at that time, sir. It is not now.

Mr. Weiss. Tell me about the complaint that was filed with HCFA in relation to Brookside. Who investigated it, what did they find, what action was taken, and what is the current status of the case?

Dr. Roper. I would be glad to discuss that with you. There was not a complaint filed. The matter first came to my attention when Congressman Stark called me and told me that he had heard about this case out there in San Francisco. He told me that he thought it was something that we ought to look into.

Let me be sure I am heard on this point, because I want to take gentle issue with my friend, Pete Stark. He told me he wanted to make sure we looked into this. I said, "Mr. Chairman, I surely will do that."

I called the San Francisco region and said—this matter has come to my attention; you ought to go look into it, and they said—you are right. In fact, we started our investigation yesterday.

My point—and let me make sure I drive it home—is HCFA began its investigation a day before Pete Stark called me. We pursued a vigorous investigation with the State agency, the State of California, and the investigation led to our concluding that there was a pattern of problems here.

We completed that survey on March 27 of this year and began the termination proceedings. That termination did not carry through because the hospital came back to us with what we judged to be an effective corrective action plan that involved having all of their hospital doctors agree to treat patients in the emergency room without regard to ability to pay.

The hospital told the doctors that they, the hospital, would pay the doctors. The hospital instituted a number of other corrective actions. HCFA rescinded its termination, referred the matter to the inspector general for judgment as to whether a penalty was warranted and have continued Brookside Hospital in the Medicare Program but with much more vigorous oversight and followup review to make sure that they adhere to their promised corrective action plan.

Mr. Weiss. I thank you very much for your participation—all three of you. The bell has rung and I have about 6 minutes to cast a vote on the catastrophic health bill substitute.

Without objection, we will enter into the record a number of statements that have been received by the subcommittee, as well as my concluding statement.

[The statements follow:]

Testimony of Lois Salisbury
on Behalf of
Coalition to Stop Patient Dumping
Before the
Human Resources and Inter-Governmental
Relations Subcommittee of the
Committee on Government Operations

July 22, 1987

I am Lois Salisbury, attorney with Public Advocates, Inc. of San Francisco. I represent the Coalition to Stop Patient Dumping, a diverse state-wide group including unions, civil rights organizations, minority groups, health care providers, consumer and advocacy organizations. The Coalition to Stop Patient Dumping has been working for the past two years to stop the tragedies for patients all over California who, in the midst of a medical emergency, go to an emergency room and are refused care, receive inadequate or delayed care, or are transferred to other medical facilities for only one reason: they do not survive the "wallet biopsy." Here are some of the recent stories:

> In Contra Costa County, Eugene Barnes was a crime victim with a knife wound to the brain. No neurosurgeon would agree to come to any of our East Bay hospitals to treat him. After several hours, he was transferred to the county hospital in San Francisco, where he died. Mr. Barnes had no health insurance.
>
> About to deliver, Sharon Ford was turned away from two private hospitals, although a fetal monitor showed fetal distress. By the time she was admitted to the county hospital, it was too late and the baby died. Although Ms. Ford was a Medi-Cal patient, enrolled in a health maintenance organization, a computer error did not show her on its list. The hospitals by mistake thought she was uninsured.
>
> William Jenness bled to death six and a half hours after a car accident in Stanislaus County. The private

hospital where he was taken asked for a $1,000 advance deposit, and transferred him to the county hospital. It took four hours before he reached the operating room. Mr. Jenness was uninsured.

In labor and uninsured, Anna Grant went to a private hospital. The hospital kept her two hours and fifteen minutes, in a wheelchair in their lobby. She was checked only once, and no tests were done which would have shown that the fetus was in profound distress. She was told to "get herself" to the county hospital, and her condition was misrepresented to the county hospital via phone. The baby was later stillborn at the county hospital, where doctors spent forty minutes in an attempted resuscitation.

David Rios was critically wounded with two gunshot wounds and brought to a private hospital in Ventura County. He was received in a medically unstable condition and in shock at the county hospital one hour and fifteen minutes later. He died later that night. Mr. Rios was uninsured. The private hospital had claimed he was stable when he was transferred.

William Trumbull sought treatment for chest pain and an unexplained shortness of breath. He died of a massive blood clot in his lung, after being discharged by a private hospital in Hayward. The hospital had not done the basic diagnostic test that would have uncovered the treatable cause of his breathing problem. Mr. Trumbull, employed as a truck driver, had no health insurance.

(See the Appendix to this testimony for thirty more recent incidents.)

The Coalition to Stop Patient Dumping is frequently asked how often these things happen. The answer is: once more is too often. Statistics are difficult to find; patients are dumped on to the streets and never come to anyone's attention. Doctors see transferred patients who should not have been moved, but don't report it, dulled to the circumstances because they have faced it too many times. Facilities attempt to work out their problems quietly through professional courtesy and protocol and the dumps continue.

We do have some data. A 1982 study of transfers to Highland Hospital, the Alameda County public hospital, found that during a six-month period, 7% of the 458 economic transfers jeopardized lives. Highland now receives twice that many transfers. And, the Alameda County District Attorney recently concluded:

> "During [our] investigation, one inescapable conclusion became clear. The general acute care hospitals licensed in Alameda County which have a 'special permit' authorizing emergency care are questioning patients who seek emergency services about their ability to pay therefore in apparent violation of State law."

In 1985, after California disbanded its Medi-Cal program for medically indigent adults and relegated them back to the counties for medical care, remarkably similar conclusions were found by a study of the San Bernardino County Medical Center. Transfers from September through November 1985 were tracked. Ninety-one percent of the 423 transfers occurred for financial reasons. Of the total, 26% were either medically indigent adults or on Medi-Cal, who were served at the County Hospital. Another 69% were transferred because they had no form of health insurance. Eight percent, or 32 of the patients were, in fact, unstable on transfer. Over 85% of those who were unstable came from the uninsured group. One death occurred. An estimated 46% of the transfers occurred without any contact between the sending and receiving hospitals: most of these patients had actually been discharged, or had not even seen a doctor when they first presented.

That same year, the National Association of Public Hospitals (NAPH) conducted a survey of hospitals across the country including California. Its survey showed that 20% of the patients were transferred with no paper work, which NAPH deems on its face to indicate an inappropriate transfer. Of the 20% who were transferred with no paperwork, the vast majority were emergency patients, many of whom required immediate admission to the hospital.

What Has Been Done

The initial focus of the Coalition to Stop Patient Dumping was on Alameda County, whose problem was most egregious. Responding to our initiative, the Alameda County Board of Supervisors passed an ordinance mandating the development of patient transfer agreements and guidelines. We negotiated and approved the guidelines, which went into effect one year ago. By setting forth procedures and obligations for both transferring and receiving hospitals, providing mechanisms for complaints and on-going monitoring, and sanctions for non-complying hospitals, including the complete rerouting of all emergency ambulance traffic away from a violating hospitals emergency room, the guidelines have helped significantly. All reports from the county hospital, Highland Hospital in Oakland, indicate a dramatic drop in the number of inappropriate emergency transfers. The problem nonetheless persists, all be it in new forms. For example, the death of William Trumbull cited above came because, although he was admitted to the hospital, he was subsequently discharged with an on-going emergency condition because he was uninsured. He died of an embolism only hours later. Similarly, patients have been turned away from emergency rooms and told to get themselves to the county hospital. There is, however, no systematic way of monitoring this sordid variation of dumping.

The Coalition to Stop Patient Dumping also proceeded to work for a statewide solution. We helped draft and develop a proposed expansion of California's prohibition on inappropriate emergency room transfers. This legislation has not yet become law, due to the vigorous opposition of only one group, the California Medical Association.

And, of course, the Coalition to Stop Patient Dumping heralded the passage of the COBRA provisions last year and welcomed the quick response of the federal government to the latest incident at Brookside Hospital in Contra Costa County, even though COBRA itself was not utilized.

What Needs to Happen

Effective legislation is needed both at the federal and state levels to stop patient dumping. The COBRA provisions are an excellent foundation for an effective federal law. Missing pieces of the law, as well as ineffective and lackluster enforcement efforts will be the subject of other witnesses' testimony at this hearing. [illegible] therefore, will only highlight a few of the obvious concerns we have with current deficiencies in federal law.

1. The On-Call Physician. The attached appendix accounts 30 plus stories of patient dumping in

California. Consistently, a major problem is the failure of the on-call specialist to come in, sometimes explicitly because the patient is not insured, other times for thinly veiled reasons amounting to the same thing. The Coalition's proposed state law specifically mandates that each hospital must ensure that its on-call physicians are available on an equal, non-discriminatory basis regardless of the patient's race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical or mental handicap, insurance status, economic status or ability to pay for medical services.

2. The Transfer Protections. The COBRA provisions prohibit a transfer unless the patient is sufficiently stabilized so that "no material deterioration of the condition is likely to result from the transfer." The Coalition urges an additional higher standard; a patient's chances of complete recovery should not be risked by a transfer. It is not enough that the patient will get no worse. How much better could they be, but for the transfer? Thus, in the proposed state legislation, a transfer is also prohibited if it will cause "a material detriment to the chances of speedy and complete recovery."

3. Mandatory Reporting. While the depth of this problem is obvious from the statistics cited above, the actual reported incidents are few. Most come to the Coalition or to lawmaker's attention through happenstance or the occasional initiative of medical personnel. A mandatory reporting obligation sets an entirely different tone than currently operates among hospital and medical personnel, which ranges from numbness to complacency to a code of silence.

4. Civil Enforcement. The personal harm suffered by a victim of patient dumping can be prolonged unnecessary pain, permanent disability or death. The threat of civil enforcement should, in and of in itself, have a preventive effect. This effect, however, is diluted if the only cases brought are those which command a potentially large damage award. Without an attorneys' fee provision, only the most egregious cases will ever be brought. For example, a parent who suffers the agony of delayed care for a hurting child may not have a large damage claim. If civil enforcement is meant prophylactically, the cases should look less like

> the classic personal injury case and more like traditional civil rights enforcement. An attorneys' fee clause should be added.

In the aggregate, of course, whatever changes and additions might be made to COBRA and whatever additional impact is gained from appropriate state laws must be viewed against the back drop of the larger problem. The Coalition to Stop Patient Dumping has no illusions about the proposed state legislation or these refinements to COBRA solving the real problem: health access is rationed in this country according to your ability to pay.

What the Coalition Has Learned about the Rationing of Health Care

The Coalition's first-hand understanding of the rationing of basic health care comes from the extensive investigation we have conducted around this state. When the Coalition to Stop Patient Dumping started fashioning proposed solutions, we began with the most obviously principled policy: prohibition of all economic patient transfers. To be sure, if there was a medical reason to move a patient from one facility to another, the transfer should occur. But economics should have no place in the evaluation of whether or not to transfer a patient.

That premise was quickly dispelled. Numerous conversations with committed, experienced medical practitioners in public hospitals reflected a common theme. These patients are better off at the public hospitals where they are wanted, than at a hospital which doesn't want them or care about them.

And, when you talk to the doctors at the private hospitals, several consistent points emerge. The emergency doctors assert quite convincingly that they are caught in the middle. They have patients who need special care, the on-call doctor won't come in or feigns an accuse, time is critical, so the patient is transferred. The back-up physicians frequently assert they are not unwilling to take care of a patient for whom they will never be paid, rather it is the increased exposure on their malpractice premium that really gets them. In the San Bernardino study, not only were the uninsured transferred in large numbers, but those with less attractive insurance were frequently transferred. There is a creaming process that goes on, picking and choosing between the insured and uninsured, and picking and choosing among the Medi-Cal and Medicare patients.

Many doctors, particularly those on the firing line in public facilities, have become inured to the problem. The Coalition's investigations have taken on a pattern. Preliminary calls to public hospital personnel reveal "no problem here." Further probing reveals that "no problem" means there are dangerous transfers several times a week. "This is not Cook County; it is not that bad." But for each of those patients, for each of those families, for each of your constituents, it is just that bad.

While the villain of the piece may ultimately be economics, the Coalition in no way absolves individual doctors and institutions from their clear responsibility to these emergency patients regardless of ability to pay. Indeed, hanging out an

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emergency shingle not only creates a legal obligation, but carries a profitable conduit for hospital admissions at a time when vacancy rates are a critical problem for many private hospitals. In California, individual hospitals and doctors have unquestionably allowed their financial balance sheet to dictate the health of certain patients.

The real difficulty faced by policy makers is not just the challenge of improving and refining the COBRA provisions or, in California, developing an effective state law to complement COBRA. Rather, the real problem is understanding the depth of the patient dumping phenomena; realizing that the stories presented today are only the most critical and heart-breaking manifestation of the daily experience millions of Americans face when trying to obtain the most basic health care for themselves and their families. Whether it is foregone prenatal care, missed immunizations, delayed cancer diagnosis, unmonitored and out of control chronic conditions such as heart-disease,diabetes or childhood asthma, each of these unattended basic health needs will eventually result in the patient who comes to an emergency room uninsured and in crisis.

The Bigger Picture

Patient dumping will grow still more serious if recent trends continue. Beyond dangerous emergency transfers, patients are dumped out of nursing homes into public hospitals, out of private hospitals into their own homes, and out of clinics into the streets. Many don't make it into a needed medical facility at all, yet alone get dumped. Impoverished families, middle income people, working Americans all face the grim possibility of denied or hazardously delayed medical treatment.

The primary cause of patient dumping is inadequate or nonexistent health insurance coverage. In 1985, 17.4% of the civilian nonagricultural population under age 65 reported no health insurance coverage from any source.[1] In California, at least 21% of persons under 65 have no health insurance. Nearly 80% of these 4.5 million people are the working poor and their children.[2] And, as the health care market grows increasingly competitive, providers restrict access through increased screening for pre-existing conditions, curtailed benefits, and complex procedures for pre-approval of care. Moreover, restrictions on eligibility for public insurance and greater cost-sharing requirements have exacerbated the pressures on both the private and public sectors. Further complicating the situation is the emergence of special populations: homeless people, deinstitutionalized mental patients, people with AIDS, refugees and undocumented immigrants.[3]

America's current crisis in health care access for the uninsured reflects dramatically converging forces. Methods of reimbursement by state and federal programs have changed radically in the last five years. In 1982, in California, for instance, medically indigent adults were dropped from Medi-Cal rolls, and the obligation of providing medical care thereafter fell onto the counties. A New England Journal of Medicine Study, published in 1984, monitored the health of 186 medically indigent adults who had been Medi-Cal patients until they were cut from the program. The participants were examined and interviewed when their benefits were cut and, again, six and twelve months later. The study concluded that, at both the six-month and one-year examination, these people suffered a significant deterioration in their health and in their access to health care.[4]

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[1] Uninsured in the United States: the Nonelderly Population Without Health Insurance, Deborah Chollet, Ph.d., Employee Benefit Research Institute, Feb. 17, 1987, p.3.

[2] Id. at 14.

[3] Health Care for the Uninsuredand Underinsured: A San Francisco Challenge, United Way of Bay Area, July 1986, p. 11.

Hospitals' behavior toward the uninsured and underinsured was adversely affected by Medi-Care's implementation of Diagnostic Related Groups (DRGs) in 1982 and similiar restrictions imposed by private insurance. Under the DRG system, hospitals are paid a lump sum for certain services provided. It thus becomes more difficult for hospitals to shift costs to other patients than it had been under the previous fee-for-service reimbursement method.

Changes in the job market have reduced the number of insured working people. Since the early 1970's, average wage and salary incomes adjusted for inflation have been declining for nearly all groups within the population and in most industries. Indeed, between 1979 and 1985, 44% percent of the net new jobs created paid poverty level wages. In addition, there has been an explosion of part-time employment. Seven out of ten part-time jobs created since 1979 have been filled by people whose part-time status is involuntary.[5] People working at poverty level wages, and in part-time jobs, have inadequate or nonexistent health care coverage.

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[4] New England Journal of Medicine, August 16, 1984 and May 8, 1986.

Without insurance, it is almost impossible for most people to obtain adequate health care. The cost of medical care rose 7.7% in 1986, seven times the increase in the overall Consumer Price Index. The cost of medical care has increased faster than the overall Consumer Price Index in each of the last six years. The 7.7% percent increase was higher than those in the three prior years; 6.4% in 1983, 6.1% in 1984 and 6.7% in 1985. But the 12.5% increase for 1981 and the 11% rise in 1982 were even greater than the increase in 1986. Elderly persons are especially hard hit by these rising costs. In 1986, elderly Americans spent 16% of their income on health care, an average $1,850 per person. Ironically, older persons are now paying a larger share of their income to health care than they did before Medicare was enacted.[6]

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[5] "A Low Wage Explosion: the Grim Truth About the Job Miracle," *New York Times*, Forum, Feb. 1, 1987.

[6] Medi-Cal Care Cost Rose 7.7% in '86, Counter to Trend, *New York Times*, February 9, 1987, p. 1.

Conclusion

All indications are that inadequate health care access will continue to be a profound problem. Short of expanding Medi-Cal and Medicare, creating a national medical insurance system, requiring all employers to provide health benefits, or substantially increasing funding for community clinics and public hospitals, America is telling its workers that their families don't deserve adequate health care. Little wonder that this country has lost its so-called competitiveness. An unhealthy, at-risk population disserves every worthy objective--be it measured in economic or human terms.

PATIENT DUMPING CASES

(DRAFT) - FOR AB 214 (MARGOLIN)

CASE NO 1: Patient: William Trumbull
Age: 27
County: Alameda

On January 4, 1987, Mr. Trumbull went to the Hayward Hospital Emergency Room complaining of chest pain and severe shortness of breath. He was admitted to the hospital after he persuaded officials there to accept a deposit of $596 instead of the $1,000 they initially requested. Mr. was discharged the next day after doctors could find no evidence that he had suffered a heart attack. However, his blood gases were not tested, despite written procedures saying that such testing should be given to patients with respiratory trouble. According to Dr. Lonny Shavelson, a physician familiar with the case, such a test would have almost certainly led to the discovery of the massive blood clot in his lung.

Mr. Trumbull's one-day stay at Hayward Hospital resulted in a $2,000 bill. Family members report that he was discharged after expressing his worries about paying the medical bills. He was so weak upon discharge that he had to sit down twice on the way to his car. "Even as a nurse was walking him to his car, he was still complaining of shortness of breath....the nurse told us she thought he should see a doctor,", said Mr. Trumbull's stepsister. Yet, the hospital had instructed Mr. Trumbull only to rest for a week and to refrain from lifting anything heavy. Fifteen hours later he collapsed in the kitchen of his home, and died shortly thereafter. The blood clot in his lung blocked the flow of blood from his lungs to his heart, essentially suffocating him.

Source: Oakland Tribune, 1/27/87.

CASE NO. 2: Patient: Sharon Ford
Age: Unknown
County: Alameda

In December 1985, Ms. Ford, nine months pregnant, went to Brookside Hospital in labor. However, once the private hospital learned that she was a Medi-Cal HMO enrollee, they refused to admit her. She then went to Merritt Hospital, which did have an HMO contract. The preliminary tests done there indicated that the fetus was in trouble. However, due to a computer error, Merritt could find no record of her current Medi-Cal coverage. Even though the baby was found to be in trouble, Ms. Ford was told that unless she had her insurance card, she would have to make her way to Highland Hospital, the county hospital. The baby's father at first could not find the card in her purse. Ms. Ford, meanwhile, was in increasing pain. When the father found the insurance card, he was told that Highland Hospital had already been called and told they were coming, and that they should proceed on to Highland.

Barely half an hour after she arrived at Highland, the baby was born dead. The Highland obstetrician said it appeared that the baby was dying slowly during Ms. Ford's 3-hour search for care. Her baby might have lived if she had been given thorough care at either of the two private hospitals.

While the Alameda County District Attorney concluded that there was no basis for criminal prosecution, he nonetheless observed:

> " we believe that Sharon Ford should never have been transferred from Merritt Hospital until further medical information was obtained on her baby, and in hindsight it is unmistakably clear that this transfer should not have been attempted without securing further information which would have indicated that emergency procedures should be completed at Merritt Hospital..."

Source: Oakland Tribune, 12/15/85; February 10, 1986 report of Alameda County District Attorney.

CASE NO. 3: Patient: PAT MCFARLAND
Age: 23 years old
County: Alameda

On October 8, 1985, Mr. McFarland caught three fingers in a machine used for customizing automobile parts. People nearby called firefighters, who arrived and bandaged his bleeding hand. The machine had ripped flesh away from bone, but most of the injured fingers were still attached.

At 6:45 p.m., an ambulance arrived and took Mr. McFarland to St. Rose Hospital, a private hospital in Hayward. At St. Rose he was given a tetanus shot and a pain killer, then was told to wait while emergency room doctors tried to make arrangements to get him transferred to Highland Hospital, the county hospital. (Mr. McFarland was uninsured.)

He spent 3 hours waiting at St. Rose, his hand throbbing in pain. Then Mr. McFarland was loaded into an ambulance and driven to Highland, but there was no orthopedic surgeon available because of a contract dispute. Although the ideal time to attempt a reattachment of his fingers had passed while he waited at St. Rose, the doctors at Highland thought there was a chance that a skilled hand surgeon could save one or more of his fingers. They tried unsuccessfully for five hours to convince another hospital to accept a transfer, or a hand surgeon to come and operate. By then, reattachment was impossible.

Finally, at 5:30 a.m., 11 hours after his injury, Mr. McFarland was taken to the operating room. Doctors amputated almost all of his small finger and ring finger and two-thirds of his middle finger.

Source: Oakland Tribune, 11/17/85.

CASE NO. 4: Patient: EUGENE BARNES
Age: 32
County: Contra Costa

At about 5:00 p.m. on January 27, 1985, Mr. Barnes sustained deep stab wounds in his left temple and was rushed to Brookside Hospital Emergency Room. His wound caused massive bleeding that built up pressure inside his skull - a life threatening condition that can worsen from minute to minute. The neurosurgeon on-call that night at Brookside, Dr. Roger Shortz, was taking care of another patient and was unavailable to examine Mr. Barnes. Dr. Shortz said he had just finished surgery on the other patient and had gone home. "There was a great possibility that the (other) patient would have to be taken back to surgery soon, and I let the emergency room doctor know that I couldn't really take on the commitment for another patient and suggested that they contact somebody else."

Brookside Hospital's emergency room doctor could find no other neurosurgeon to come and see him (two refused) and no other East Bay hospital (three refused) where a neurosurgeon would come in. Ms. Marge Woolf, an administrator at Contra Costa County Hospital, one of the hospitals called by Brookside explained: "We contacted our neurosurgeon who had just completed a similar case and had been on his feet all day. He said he didn't feel good about starting another case of this sort."

Five hours later, Mr. Barnes was transferred to San Francisco General, where he underwent extensive surgery. However, by morning, Mr. Barnes was in a coma and "brain dead". He died at 8:45 a.m. two days later. According to a physician at San Francisco General, Mr. Barnes might have lived had he undergone surgery soon after he was brought to Brookside Hospital.

Source: San Francisco Chronicle, 2/2/85.

CASE NO. 5: Patient: DAVID RIOS
Age: 30 years old
County: Ventura

In early January, 1986 at 7:45 p.m., Mr. Rios was brought to a private hospital, St. John's Regional Medical Center. Even though he had been critically wounded with two gunshot wounds in his chest, within 30 minutes of his arrival at the hospital, they transferred him to the County Medical Center, claiming he was in stable condition. (Mr. Rios had no insurance coverage.) Doctors at the county hospital said that he arrived in a medically unstable condition and in shock. Mr. Rios died in surgery two hours after his arrival at County Medical Center.

Source: The Ventura County Star Free Press, 1/11/86.

CASE NO. 6: Patient: WILLIAM JENESS,
Age: 24 years old
County: Stanislaus

On his way home after a 12-hour work day on January 17, 1984, Mr. Jenness sustained a severe chest injury when his car crashed into the back of a bus. He was found lying on the shoulder of the road, incoherent and with dangerously low blood pressure. He was immediately taken to the closest hospital, Memorial Hospital in Modesto. By the time the ambulance reached Memorial, thanks to the treatment given by ambulance nurses, Mr. Jenness' blood pressure was close to normal, his skin was pink, and he was awake and talking. An arteriogram showed that Mr. Jeness had a tear in his aorta, the large artery leading from the heart that carried blood to all parts of the body. However, once it was determined that he had no medical insurance and could not make the required $1,000 deposit, the hospital made arrangements for him to be transferred to the county hospital, Scenic Hospital. This was done despite efforts by Mr. Jenness' family to convince the hospital to accept partial payment for the required deposit or accept a credit card. Memorial Hospital had the capacity to do the necessary surgery, and it is illegal to require that people pay in advance for emergency care. Dr. Donald Trunkey, a San Francisco surgeon and chairman of the American College of Surgeon's Committee on Trauma, said accident victims with severe chest injuries such as Jeness have a much better chance of surviving if they reach surgery within an hour.

Four hours elapsed between the time of the accident and Mr. Jeness' arrival at the county hospital. A surgical team at Scenic General struggled to patch five tears in Mr. Jenness' heart. Two and a half hours later, Mr. Jenness died in surgery. An autopsy report said that almost a quart of blood was found in his chest.

Source: The Modesto Bee, 4/15/84.

CASE NO. 7: Patient: GAYLEN WILLIS
Age: Unknown
County: Alameda

On November 20, 1985, Mr. Willis sustained a shotgun blast to his back and was taken to nearby Alta Bates Hospital, a private hospital. There, he received only minimal care - not even a cleaning of the fist-sized wound - while family members were sent to his home to search for proof of insurance coverage. The emergency room doctor at Alta Bates wanted to transfer Mr. Willis immediately to Highland Hospital (the county hospital) but Highland had no intensive care beds available and could not accept the transfer even if the patient was stable enough to travel.

By late the following afternoon, Highland had an opening in its intensive care ward. Seventeen hours after he was shot, and in excruciating pain, Mr. Willis was transferred. As soon as he arrived, doctors cleaned the wound and administered a painkiller. According to one doctor at Highland, the wound had become infected and the leak of his spinal fluid put Mr. Willis at substantial risk of meningitis. He underwent 6 hours of surgery to remove more than a dozen shotgun pellets from his back.

A State Department of Health Services investigator stated that "the 17 hour delay in surgical care.....posed a medical risk to the patient. The presence of clothing and shotgun wadding in the wound at the time of transfer further exacerbated the problem. Alta Bates had all the resources necessary to provide prompt and appropriate care."

Source: Oakland Tribune, 11/29/85; letter from Mr. Hank Schoenlein, Regional Administrator of Licensing and Certification, State Department of Health Services, 1/15/86.

CASE NO. 8: Patient: CHILD A
Age: 15 years old
County: San Bernardino

In about May 1985, Dr. Max Lebow, Director of Clinical Services at San Bernardino County Medical Center received a call from one of the local hospitals saying they had a 15-year old boy who had been stabbed in the chest several times. As this patient had no apparent means of support, they wanted to transfer him to the county hospital. Dr. Lebow refused the transfer due to the grossly unstable condition of the boy, and told the hospital that he needed to be operated on where he was.

An hour later, Dr. Lebow received a call back and was told that the thoracic surgeon at the hospital believed this patient was stable enough to come to the county hospital and that they were going to send him.

> "I again refused (the transfer) emphatically.
> I told him that no, while I didn't have the
> patient in front of me, anyone who was stabbed
> in the chest 3 times, by my standards, is unstable.
> Well, I got a call,another call, an hour later.
> The patient still was just lying in the emergency
> room a this other hospital. He had not been
> treated yet and I was getting pretty nervous.
> So I said "well look, if you're not going to do
> anything for this kid, send him over."

When the patient arrived at the Medical Center Emergency Room, 2 1/2 hours after he was brought to the private hospital, he was very pale with barely palpable blood pressure. Although he was still alert and talking, he had engorged neck veins, indicating that one of his stab wounds had entered his heart. He was in the operating room within 5 minutes of arrival at the hospital. But, 20 minutes later, this 15-year-old boy was dead.

Source: Testimony of Dr. Max Lebow, Director of Clinical Services at San Bernardino County Medical Center, Oversight Committee hearings 11/19/86.

CASE NO. 9: Patient: MS. A
Age: Unknown
County: Santa Clara

Dr. Stanley Shatsky, a Stanford University neurosurgeon at Valley Medical Center (a public hospital in San Jose, Ca.) received a call from a doctor at another hospital requesting permission to transfer an uninsured patient who had been badly hurt in an automobile accident. The patient had been on a mechanical breathing device for five days; the respirator had just been removed. She had had three brain operations, was comatose, paralyzed on one side of the body, and had a fever. Dr. Shatsky said that the county hospital would accept the transfer when the patient was medically stable. In the other doctor's estimation, the patient was unstable, not ready for transfer for about three days.

Later that same day, Dr. Shatsky discovered a female patient at Valley Medical Center who had been deposited on a bed with no medical chart. He recounts:

> " there was no discharge summary, no medication records, no x-rays whatsoever. She was comatose, had surgical incisions for brain operations on both sides of her head; the brain was bulging out of one of these incisions. She had a fever of 103 and was paralyzed on the left side of her body. The patient went into respiratory distress (couldn't breathe well enough on her own), and left on her own, would have died. Later on, I called up the doctor (at the other hospital), and said "Look, we just talked a few hours ago and you said you were going to transfer the patient when you thought she was stable, in three days." And he said "I never sent the patient. That was all done by the hospital. I never wrote a discharge summary or orders to transfer."

Source: Interview with Dr. Shatsky on National Public Radio, conducted by Mr. John McChesney, July 1985.

CASE NO. 10: Patient: MR. D
Age: Unknown
County: Alameda

On November 1, 1985 at about 10:45 p.m., an uninsured man with a gunshot wound was brought into Providence Hospital. According to Providence administrators, his condition was stabilized, X-rays were taken and a surgeon was called. The Providence emergency room doctor then convinced Highland Hospital (the county hospital) doctors to accept the patient's transfer. An ambulance was called to make the transfer at about 12 midnight; it was designated a non-urgent call and the ambulance arrived at 12:45 a.m.

By then, two hours after the man was brought in to Providence Hospital, the patient's blood pressure was dropping and he was going into shock due to the loss of blood from internal bleeding. However, the single Providence emergency room doctor was occupied with another emergency and the surgeon was no longer in the hospital. The Providence emergency room doctor called again and convinced Highland doctors to let the transfer go through even though the man was no longer in stable condition. This was suggested as the quickest way to get the man to surgery.

The man ultimately arrived at Highland at about 1:20 a.m., gray with shock, without adequate IVs and with no doctor riding in the ambulance. In the ambulance, he had nearly died because the bullet had collapsed his lung, destroyed his spleen and continued heavy internal bleeding. He was rushed into surgery, where it was found that about 60% of the blood in the man's veins had bled into his chest and abdominal cavity. Although the man survived, the delay in treating him, and his transfer to Highland Hospital, caused an extremely serious and unnecessary threat to his life.

Source: Oakland Tribune, 11/10/85

CASE NO. 11: Patient: MR. B
Age: 36
County: Alameda

An uninsured Hispanic man was found after a beating and taken to a private hospital where he lapsed into a coma. The private hospital chart documents that two neurosurgeons refused to see the patient despite urgent requests from the emergency room physician. He was transferred to Highland Hospital where he was found to have a fractured skull. The patient never regained consciousness.

Source: Himmelstein et al; "Patient Transfers; Medical Practice as Social Triage"; American Journal of Public Health, May 1984, p. 494.

CASE NO. 12: Patient: MICHAEL MURPHY
Age: 27 years old
County: Fresno

Mr. Murphy was injured in an aircraft accident and suffered several severe fractures. Treatment was delayed because of an economically motivated transfer from Saint Agnes Hospital. (Mr. Murphy had no insurance.) He arrived at Valley Medical Center 27 hours later with severe fracture blisters and a deteriorated skin condition that prevented surgery. The skin condition posed too great a risk of infection for surgery at that time. Mr. Murphy is now left with permanent partial impairment and degenerative arthritis in the ankle, a major weight-bearing joint.

Source: Letter of Dr. W. Berman, Assistant Chief of Orthopedic Surgery at Valley Medical Center, 11/19/86; Senate Heath and Human Services Hearing on AB 3403, July 1986.

CASE NO. 13: Patient: MS. B
Age: Unknown
County: Santa Clara

A young woman was first seen late at night in a private hospital's emergency room. She had had three days of a sore throat and was developing a posterior abscess in the back of her throat. There is a significant chance that such an abscess will block the airway, causing suffocation, and so they are considered emergencies. These abscesses need to be excised and drained immediately. The diagnosis was accurately made at the private hospital but because the patient was unsponsored, she was told to seek her own specialist as soon as possible.

The next morning, the woman went to the Valley Medical Center Clinic (a public hospital in San Jose) where Dr. Low saw her. She was drooling because she could not swallow her own saliva, and was gagging and barely able to speak. Dr. Low got her immediately to the ear-nose-throat department, where they drained the abscess right away. The abscess was just about to block the patient's airway; without prompt attention she could easily have died.

Source: Interview with Dr. Dennis Low of Valley Medical Center on National Public Radio, conducted by Mr. John McChesney, July 1985.

CASE NO. 14: Patient: MR. C
Age: Elderly
County: Alameda

An elderly man arrived at the West Oakland Health Clinic on November 6, 1985 in severe pain, vomiting blood. The clinic doctor called Herrick Hospital, a private hospital with a Medi-Cal contract, and requested his admission; Herrick had medical records on the man because he had been treated several months earlier for a different ailment. But in this instance, Herrick refused the clinic doctor's request for admission of the man because they were unclear whether he was still covered by Medi-Cal.

The clinic doctor then called an ambulance and arranged for the man to be transferred to Highland Hospital, the county hospital, although doctors there had not approved the admission. When he arrived, Highland's intensive care beds were full. There followed another round of negotiations with Herrick Hospital, during which it was discovered that the man was covered by Medi-Cal after all. He was then transferred back to Herrick, where he was admitted.

Source: Oakland Tribune, 12/16/85.

CASE NO. 15: Patient: MR. D
Age: Unknown
County: Alameda

On September 6, 1985, a man fell under a train which partially severed his foot. The man was brought to Highland Hospital (the county hospital), but the hospital did not have an orthopedic surgeon available. Doctors called Oakland area hospitals seeking a transfer. None of the hospitals would accept him. By the time the man was transferred - to San Francisco General - it was too late for reattachment.

Source: Oakland Tribune, 11/1/85.

CASE NO. 16: Patient: LUPE VILLAREAL
Age: 15 years old
County: Fresno

Lupe Villareal suffered a severe fracture of the left leg with a rupture of the main artery supplying blood to the lower leg and foot. He was first seen at Hanford Sacred Heart Hospital where treatment was delayed approximately 11 hours for unknown reasons before he was transferred to Valley Medical Center. Surgery at Valley Medical Center was too late to prevent muscle and nerve death (due to lack of blood) below the knee. Lupe Villareal now has a stiff, insensitive and immobile foot and ankle, and he remains at risk of amputation due to lack of feeling and flexibility in the foot.

Source: Letter of Dr. W. Berman, Assistant Chief of Orthopedic Surgery at Valley Medical Center, 11/19/86; Senate Health and Human Services Committee Hearing on AB 3403, July 1986.

CASE NO. 17: Patient: MR. E
Age: Unknown
County: Alameda

On March 11, 1985, a man went to Memorial Hospital in San Leandro coughing up blood and suffering from both tuberculosis and pneumonia. He was admitted to the intensive care ward for four days and placed on a breathing tube. When the tube was removed, he was observed for 1 hour for signs of trouble, given a 10-day supply of medicine and a surgical mask to cover his mouth, and discharged with instructions to seek care at Highland Hospital (the public hospital). According to Highland sources, he was gravely ill when a relative brought him by car to Highland Hospital. The man appeared to be in no condition to be discharged directly from the intensive care unit. According to these sources, Memorial did not follow normal transfer procedures because they have had trouble getting Highland to approve transfers of this type.

Source: Oakland Tribune, 11/1/85.

CASE NO. 18: Patient: ARTHUR NUNEZ
Age: 2 1/2 years old
County: Fresno

In late 1985, Arthur Nunez suffered a right knee injury while playing that resulted in a bone fracture and the rupture of the main artery supplying blood to the lower leg and foot. He was first seen at Valley Children's Hospital, but because that hospital did not have a Medi-Cal contract, Arthur was transferred to Valley Medical Center. At Valley Medical Center, several emergency cases that required immediate surgery and came in at the same time as Arthur prevented him from being taken to the operating room until 6 hours after admission. Because of the 6-hour delay, he showed signs of permanent muscle and nerve damage below the knee by the time he reached surgery. He still remains at risk of amputation due to lack of feeling and flexibility in the foot.

Source: Letter of Dr. W. Berman, Assistant Chief of Orthopedic Medicine at Valley Medical Center, 11/19/86; Senate Health and Human Services Committee Hearing on AB 3403, July 1986.

CASE NO. 19: Patient: ANNA GRANT
Age: Unknown
County: Alameda

Ms. Grant, 9 months pregnant and with no insurance, sat in labor for three hours in the Brookside Hospital waiting room. She was not evaluated by an obstetrical consultant during this time. Finally, her cousin prevailed on the hospital to call an ambulance to take her to the county hospital in Martinez. There, her baby was born dead. According to a doctor familiar withe the case prompt attention at Brookside might well have helped increased her baby's chances of survival.

Source: Oakland Tribune, 4/6/87.

CASE NO. 20: Patient: MR. F
Age: Unknown
County: Alameda

An uninsured man was kicked in the stomach the day after Thanksgiving in 1985. He was brought to Herrick Hospital (a private hospital) Emergency Room, examined and told to go home.

He returned six days later in extreme pain. The man was treated by the emergency room doctor, but no surgeon came in for a consultation. Instead, once the hospital learned the man had no insurance they transferred him to Highland Hospital (the county hospital) because he lacked insurance.

When he arrived at Highland, he was near death, according to persons familiar with the case. He was rushed into surgery, where it was discovered that the kick to his stomach had ruptured his intestine. As a result, his stomach cavity had filled with blood and feces, causing a severe infection. "It was instantly apparent (that) he had a classic acute (infection of the) abdomen", said one source. "He was critically ill and it was clearly a life-threatening infection. He wouldn't have survived more than another couple of hours." According to this person, it is possible that the severity of the injury was not apparent at the man's first hospital visit a week earlier. However, standard medical practice with such a patient is to admit him or her for observation, which was not done by the private hospital in this case.

Source: Oakland Tribune, 12/16/85.

CASE NO. 21: Patient: CHILD C
Age: unknown
County: San Diego

In 1985, an uninsured adolescent boy was stabbed. His mother took him to several private hospitals, but none would admit him. Finally, she got her other son's insurance card and represented that he was the one insured. Only through that misrepresentation could she obtain emergency medical care for her son.

Source: Ms. Sharon Kraft, Palomar Hospital, San Diego, 2/85.

CASE NO. 22: Patient: NICX TREVINO
Age: 43 years old
County: San Diego

On Christmas Day, 1984 at 11:55 a.m., Mr. Trevino was shot in the belly. Paramedics responded quickly, treating the patient briefly before speeding him to Grossmont District Hospital, which was the trauma center for the most severely injured patients in the eastern part of the county.

But when they arrived at the hospital, there was no surgeon available to perform the immediately needed surgery (although one was required by law to be present). Life Flight helicopter service was called for assistance in order to fly Mr. Trevino to the Trauma Center at UC San Diego Medical Center. According to Life Flight personnel: "He was in shock in the emergency room at Grossmont. Their operating room was ready to go. There was no trouble getting blood. But there was no surgeon in-house."

Mr. Trevino was flown to UCSD Medical Center, where he was rushed to the operating room. Approximately 40 minutes had passed since he had first been taken to Grossmont District Hospital. But, UCSD's trauma team was unable to save him.

Source: San Diego Union, 1/1/85

CASE NO. 23: Patient: MR. G
Age: Unknown
County: Ventura

According to Dr. Baumer, Director of Emergency Services at County Medical Center, the staff of a private hospital recently attempted to load a gunshot victim in unstable condition into an ambulance for the 15- mile drive to the county hospital. (The patient was uninsured.) But the condition of the patient deteriorated so rapidly that the doctors at the private hospital had to remove him from the ambulance before it even left, and rush him into surgery, where he nonetheless died.

Source: The Ventura County Star Free Press, 1/19/86.

CASE NO. 24: Patient: MARVIN ZARATE
Age: 24 years old
County: Fresno

On May 13, 1986, Mr. Zarate was involved in a car accident near Lodi, and was taken to Lodi Hospital with fractures of the left femur and left 10th rib. For unknown reasons, the patient was transferred after 10 to 12 hours without treatment to stabilize the femur fracture, to Valley Medical Center. There, Mr. Zarate developed several severe complications related to the femur fracture (including shock lung and adult respiratory distress syndrome), and one month later while in the intensive care unit he died from these complications. Early treatment to stabilize femur fractures has been shown to minimize the risk of disability or death. Mr. Zarate might be alive today if treatment had been prompt.

Source: Letter of Dr. W. Burman, Assistant Chief of Orthopedic Surgery at Valley Medical Center. 11/19/86; Senate Health and Human Services Committee Hearing on AB 3403, July 1986.

CASE NO. 25: Patient: MS. C
Age: Unknown
County: Alameda

A severely depressed uninsured woman slashed her wrists so deeply that she severed key muscle and nerve tissue. The private hospital she was taken to transferred her to Highland Hospital (the county hospital) as a psychiatric case rather than treating her medical injuries. Doctors in a private emergency room superficially bandaged her wounds before she was transferred.

Source: Oakland Tribune, 11/10/85.

CASE NO. 26: Patient: MARIA CEJA
Age: 42 years old
County: Alameda

In April 1985, Ms. Ceja, an Oakland mother of three died, after being transferred to three Bay Area hospitals. Ms. Ceja, whose heart had been damaged by rheumatic fever in childhood, had agreed to catheterization and heart surgery three weeks before her death, after months of delaying the decision because she was fearful of the surgery.

However, by the time she agreed to the surgery, her doctor was concerned that the surgery be done at a hospital where she could be rushed into open-heart surgery if necessary. On April 1, Ms. Ceja was admitted to Oakland Hospital for the catheterization and her doctor, Dr. Padilla, tried to make arrangements for the heart surgery that would probably be necessary. After obtaining Medi-Cal approval for a transfer to a hospital out-of-county (since none in-County would admit a Medi-Cal heart surgery patient), Dr. Padilla tried to admit Ms. Ceja to the UC San Francisco cardiology department but was told (in error) that it could not accept a Medi-Cal patient. Instead, Dr. Padilla had her admitted to San Francisco General (the county hospital) for the heart catheterization, but due to the week-long delay and transfer, Ms. Ceja's condition had deteriorated so much that it was no longer safe to do the procedure.

Five days later, the catheterization was done, confirming the need for heart surgery. Ms. Ceja was transferred to Seton Medical Center in Daly City, which offers heart surgery to Medi-Cal patients. But she died of heart failure the following day, sixteen days after she was first hospitalized and 8 hours before her surgery was scheduled. Her doctors charge that she died because there is no hospital in Alameda County that offers heart surgery to Medi-Cal patients.

Source: Oakland Tribune, 4/23/85.

CASE NO. 27: Patient: MS. D
Age: 54 years old
County: Orange

In September 1986, a woman went to the Share Our Selves (S.O.S.) free medical clinic in severe pain from gallstones. An S.O.S. specialist examined her and sent her to the emergency room of a Medi-Cal contract hospital. There, she was told she had not yet been funded for Medi-Cal, and that she would not be treated until she "blocked" (which would be a life-threatening situation). She was given a shot of Demerol and sent home.

This happened four times: she went to the emergency room in severe pain, and was sent home with a shot of Demerol and a vial of codeine and Tylenol. No one would see her or admit her because she was unfunded.

She was able to get emergency Medi-Cal stickers, but even then the hospital would not admit her until they received written authorization from Medi-Cal which took an additional 15 days to get. The Director of the hospital indicated he would not take verbal authorization because he was afraid it would not hold up for reimbursement. In all, this woman spent several weeks in needless pain because of the hospital's refusal to see her until her funding situation was resolved.

Source: Testimony of Vicki Mayster, Director of S.O.S. free medical clinic; Oversight Committee hearing 11/19/86.

CASE NO. 28: Patient: MR. H
Age: Unknown
County: Alameda

On September 2, 1985, a man was severely beaten. He was taken tp Providence Hospital ~~to Highland Hospital~~, a private hospital. He was diagnosed as a psychiatric patient because he had been acting belligerently, and then transferred to Highland Hospital, the county hospital. Once at Highland, it was discovered that he had a broken rib, a collapsed lung, several broken bones in his face and a concussion. These medical injuries were not diagnosed or treated at Providence Hospital.

Source: Oakland Tribune, 11/10/85.

CASE NO. 29: Patient: MR. SHERBURNE
Age: Teenager
County: Orange

Mr. Sherburne was assaulted by muggers at 11:15 p.m. on November 22, 1986 and sustained a deep cut in his upper lip. He was taken to Buena Park Community Hospital for emergency medical care, where it was determined that the cut required a plastic surgeon because of the intensity of the wound. Buena Park Community did not have a plastic surgeon available, and so they suggested to Mr. Sherburne that he go to West Anaheim Hospital. He (and his father who accompanied him) was informed that someone would be waiting there for them.

Upon their arrival at West Anaheim, Mr. Sherburne and his father were advised by the desk clerk and attending doctor that the plastic surgeon was unavailable because he was about to embark on a trip and because Mr. Sherburne was considered a "cash account" (a case without medical insurance). A return to Buena Park Community was suggested.

When Mr. Sherburne and his father returned to Buena Park, they were advised that nothing had changed, but the attending nurse said that she would do everything possible to find someone who could help.

At about 1:15 A.M., three hours after he was attacked and with essentially no medical care, the nurse recommended that Mr. Sherbourne go to UC Irvine Medical Center. She cautioned them not to mention having already been seen at Buena Park or West Anaheim because Irvine Medical Center might then insist on a return to one of those hospitals.

Upon their arrival at Irvine Medical Center, the attending doctor did indeed suggest that they return to Buena Park, then stated that they would perform the treatment at UCI with a $25 deposit. However, even after this deposit was paid, at about 1:50 A.M., it was not until about 4:00 A.M. that Mr. Sherburne finally received treatment - jurisdictional discussions continued within his earshot until that time. In all, almost 5 hours elapsed between the time Mr. Sherburne was attacked and when he was treated.

Source: Letter of Mr. Eric Sherburne, patient's father, received 12/3/86.

CASE NO. 30: Patient: MR. H
Age: Unknown
County: Alameda

A young uninsured man was brought by ambulance to Kaiser Hospital in Richmond at 4:00 a.m. on October 1, 1985. He spent an hour and a half waiting in the emergency room there while doctors tried to find a neurosurgeon. According to one doctor familiar with the case: "It was grossly inappropriate for this man to have been taken to Kaiser Richmond in the first place because they never have a neurosurgeon there."

At 9:45 a.m., 1 hour and 45 minutes after he was admitted to Kaiser, he was transferred to Highland Hospital, the county hospital. But, by then it was too late to repair the damage of a brain hemorrhage, and the man died.

Source: Oakland Tribune, 11/18/85.

CASE NO. 31: Patient: CHILD B
Age: Unknown
County: San Diego

In 1985, a boy fell off his bicycle onto a fire hydrant and suffered a ruptured liver. He had been a patient at a small health maintenance organization that was going out of business. With his insurance status in question, his mother took him to three private hospitals (Ville View, Harbor City, and Mercy). Treatment was denied at the first two hospitals; he was treated at Mercy Hospital and survived. This delay in treatment caused several hours of unnecessary pain for this child.

Source: Mr. Rex Dalton, San Diego Union, 2/86.

CASE NO. 32: Patient: CHARLES JONES
Age: Unknown
County: Contra Costs

On October 6, 1984, Mr. Jones, suffering from congenital heart disease, was taken to Brookside Hospital, a private hospital. The hospital transferred him to Contra Costa County Hospital when it discovered he was uninsured. There, Dr. Roger Barrow diagnosed him as needing immediate heart surgery to replace a failing heart valve. However, the heart surgery was not scheduled at that time and instead he was discharged from the hospital.

On January 3, 1985, Mr. Jones was readmitted into Contra Costa County Hospital. He was suffering from severe chest pain and was having great difficulty breathing. On January 13, 1985, Mr. Jones died of heart failure without ever receiving the needed surgery.

Source: Suit filed on behalf of Mr. Jones' children in the U.S. District Court by Mr. Stephen Schear, attorney with East Oakland Community Law Office, 1/10/86.

CASE NO. 33: Patient: MICHELLE FLAHIVE
Age: 18 years old
County: Fresno

Ms. Flahive was in an automobile accident in Yosemite Park and was brought by helicopter to Saint Agnes Hospital. She was transferred to Valley Medical Center 2 1/2 days later without having received any specific treatment for a broken and dislocated hip. As a result of this delay, Ms. Flahive is likely to be partially disabled for the rest of her life with degenerative arthritis of the hip.

Source: Letter of Dr. W. Berman, Assistant Chief of Orthopedic Surgery at Valley Medical Center, 11/19/86; Senate Health and Human Services Hearing on AB 3403, July 1986.

Statement

of the

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

to the

HOUSE GOVERNMENT OPERATIONS SUBCOMMITTEE

ON

HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS

RE: Equal Access to Health Care

July 22, 1987

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The American College of Emergency Physicians (ACEP) appreciates this opportunity to submit a written statement to the House Government Operations Subcommittee on Human Resources and Intergovernmental Relations addressing the issue of "equal access to health care."

The College is a national medical specialty society that was founded in 1968 to further the discipline of emergency medicine. ACEP's membership now includes more than 11,000 emergency physicians who practice their specialty in emergency facilities throughout the United States. Each year, approximately 80 million visits are made to emergency facilities by patients who depend upon the specialized training and expertise of emergency care providers to stabilize and treat virtually every type of serious illness and injury. Emergency physicians constitute the front-line of American medicine and, in many instances, they are effectively the only outpatient health care providers for a substantial portion of the nation's poorest citizens.

The College believes that the objectives of this oversight hearing by the Human Resources and Intergovernmental Relations Subcommittee in attempting to focus on the economic causes and medical implications of inappropriate patient transfers and the federal role in preventing them are laudable. There can be no question but that the health and safety of each patient is of paramount importance and that no patient should be denied access to emergency medical treatment simply because he or she may lack the ability to pay. Emergency physicians in particular have discharged their obligations in this regard with the utmost attention to the professional standards of their discipline and the public interest.

The central point is that the subject of inappropriate patient transfers is a complex issue whose full dimensions are not yet clearly understood. "Patient dumping" is not a topic which is susceptible to quick and universal explanation, nor can a comprehensive solution be arrived at in isolation without addressing the broader issues of indigent care and the role of other physicians and administrators. Clearly, not all physicians or medical facilities have the capabilities to care for every patient. Therefore, patient transfers have become an everyday occurrence in today's health care environment.

Recent changes in the health care industry have affected the delivery of medical services to the poor. The rapid introduction of competitive forces into the delivery of health services during the past few years has made it increasingly difficult for the private sector to absorb the costs of uncompensated care. The implementation of the Prospective Payment System for Medicare reimbursement to hospitals has exerted significant downward pressures on all hospital charges, eliminating the margin that used to be available for other purposes, such as the financing of indigent health care. In addition, both consumers and third-party payors have become increasingly cost-conscious, and organized health care coalitions and new forms of managed care plans have reduced hospital utilization rates and cut average patient lengths of stay. There has also been a decreasing emphasis upon the provision of inpatient hospital services.

It is within the context of these sweeping changes in the health care industry that the issue of inappropriate patient transfers must be considered. The economic pressures generated by new competitive forces have increased the incentives to transfer patients to publicly-supported facilities where those patients may be eligible to receive free or reduced-cost medical care that is subsidized by tax revenues. However, although the subject is a complex one, and its nature and dimensions vary widely among localities, the College believes that physicians and hospitals must continue to render emergency medical care in a professional manner in which courses of treatment are decided upon on the basis of each patient's particular needs. Placing the patient's interests first, and rendering the highest quality care without regard to the patient's ability to pay will result in the elimination of the problem.

With the passage of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Congress prohibited the transfer of medically unstable patients. The law imposes stiff fines and possible termination of Medicare provider agreements for hospitals and physicians who violate its requirements. Since the legislation was enacted, ACEP has been working with its membership to help them develop a better understanding of the law's requirements and to foster continued compliance with the COBRA provisions dealing with patient transfers. Several comprehensive articles about the legislation, its requirements, and other pertinent information have been included in the College's monthly newsletter, ACEP News, which is distributed to the entire ACEP membership. In addition, the College had developed guidelines prior to the enactment of COBRA concerning patient transfers from emergency departments (Attachment 1) and made the document available to all emergency physicians. The College also worked with legal counsel to develop an interpretation of the COBRA patient transfer requirement and made this document available to emergency physicians across the country. ACEP continues to develop and implement strategies designed to help emergency physicians understand their role in solving the indigent care and inappropriate patient transfer problems facing this nation.

Although the College has expended a great deal of effort to help its members better understand the problems associated with indigent care and inappropriate patient transfers, a great deal of work is left to be done. The problem cannot be viewed in isolation of the economic and medical/social factors influencing it. Just as medical care involves a systematic approach to identifying the patient's medical problems and implementing a reasonable course of action to address those problems, the issue of inappropriate patient transfers must be looked at in terms of the duties and activities of the overall health care system. Why does the problem exist? What forces perpetuate the problem? The College believes these questions must be answered before any permanent solutions can be developed.

Because stories of inappropriate patient transfers and "patient dumping" have continued to appear in the media, the College has focused its attention on what may truly be the root of the problem. The emergency physician and the emergency department have been the focus for the inappropriate patient transfer problem. From the emergency physician's standpoint, however, there may be circumstances beyond his or her control which may better explain why the problem continues to exist. There is no dispute that, occasionally, physicians will arbitrarily transfer seriously ill and injured indigent patients to public facilities. When it does occur, those physicians and hospitals involved should be held accountable according to the laws and guidelines that have been established to address these actions.

The practical operation of patient transfer decisions too often places emergency physicians in the intractable position of having to provide extended care to emergency patients who might encounter some risk in transport. Most emergency physicians do not have admitting privileges in the hospitals in which they practice. If an emergency physician is unable to locate a staff doctor willing to admit and accept responsibility for the treatment of a patient, the emergency physician would then be faced with the impossible choice of either transferring the patient and risking eventual prosecution or retaining the patient in the emergency department. Faced with this dilemma, emergency physicians have looked to the College for guidance.

At its June 1987 Board of Directors' meeting, the American College of Emergency Physicians adopted two policy statements concerning definitions contained in the COBRA patient transfer legislation. By developing and adopting these positions, the College hoped to address the situation described in the preceding paragraph and provide some guidance for its members. The first policy dealt with "medical screening exams":

> "Every patient, regardless of ability to pay, should receive a medical screening examination to determine whether or not an

> emergency condition exists. Such screening examinations should be performed by a physician. In the event a physician is not physically present in the emergency department 24 hours a day, the screening exam may be performed by properly trained ancillary personnel according to written policies and procedures."

In addition, the College developed a definition of a "responsible physician" for the purposes of the COBRA patient transfer legislation. We do not believe that the definition of "responsible physician" under current law is as broad as the College envisions. Therefore, the Congress may wish to review the definition of "responsible physician." The policy adopted by the College is as follows:

> "The American College of Emergency Physicians has consistently emphasized the responsibility of all physicians to adhere to the highest standards of medical care and ethics and to contribute to the health care needs of the medically indigent. Therefore, the College believes that all hospitals must provide a call schedule of appropriate medical specialists to provide ongoing, definitive treatment to the patient after initial examination by emergency physicians. In addition, the term "responsible physician" should be broadened to include any physician on the medical staff who, by nature of a call schedule or because of an existing physician-patient relationship, is required to assume the care of patients presenting to the emergency department after initial examination by emergency physicians."

The American College of Emergency Physicians firmly believes in the right of every patient to be treated with dignity and compassion. Appropriate medical care should be available to every individual, regardless of economic status. As the national professional society of emergency physicians, ACEP will continue to support measures designed to strengthen and improve the provision of emergency medical services and to attain the goal of a society in which access to medical care is available to every person in need. Inappropriate patient transfers are only one manifestation of the fact that America has not yet reached that goal. A solution to this issue can be found, but it must be one which combines concern for the rights and dignity of the individual patient with an appreciation for the difficult and demanding challenges of the profession of emergency medicine.

The American College of Emergency Physicians stands ready to work with this subcommittee, Congress, the Health Care Financing Administration, and others interested in formulating a reasonable and effective solution to this important issue. Ms. Virginia Pitcher, Director of the College's Washington, D.C., Office, may be contacted at (202) 861-0979 for further clarification of the points made in this statement, or, for additional information on College activities in this area.

Attachment 1

Guidelines for Transfer of Patients

[This document was developed by the American College of Emergency Physicians Government Affairs Committee, and was approved by the Board of Directors on August 13, 1985. It is a revision of a document adopted by the Board of Directors in September 1977 and published in JACEP *1977;6:467. These are guidelines, and are not to be construed as standards of care. American College of Emergency Physicians: Guidelines for transfer of patients. Ann Emerg Med December 1985;14:1221-1222.]*

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From time to time, patients in an emergency department are transferred to other facilities. The transfer may be made to another emergency department or directly to an inpatient facility. Clearly not all physicians or medical facilities have the capabilities to care for every patient. At times patients, or those responsible for them, request transfer to another facility for various reasons (which may or may not be medical), at times patients are transferred to receive the benefit of more appropriate facilities and/or services than are available in the given hospital or emergency department, and at times patients are transferred because of economic considerations, which may include the availability of free or reduced-cost medical care at a public or other facility or in accordance with the requirements of preexisting contracts for patients of prepaid health plans that stipulate which facilities patients are to use.

Patients should not be transferred to another facility without first being stabilized. Stabilization includes adequate evaluation and initiation of treatment to assure that transfer of a patient will not, within reasonable medical probability, result in death or loss or serious impairment of bodily functions, parts, or organs.

Evaluation and treatment of patients prior to transfer should include the following:

1. Establishing and assuring an adequate airway and adequate ventilation;
2. Initiating control of hemorrhage;
3. Stabilizing and splinting the spine or fractures when indicated;
4. Establishing and maintaining adequate access routes for fluid administration;
5. Initiating adequate fluid and/or blood replacement; and
6. Determining that the patient's vital signs (including blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate perfusion. The vital signs should remain within these parameters for a sufficient time prior to transfer in order that the physician may be reasonably certain that they will not deteriorate while the patient is en route to the receiving hospital.

There may be times, however, when stabilization of a patient's vital signs is not possible because the hospital or emergency department does not have the appropriate personnel or equipment needed to correct the underlying process (eg, thoracic surgeon on staff or cardiopulmonary bypass capability). In these cases, steps 1 through 5 should be performed and transfer should be carried out as quickly as possible.

A patient, or those responsible for the patient, may request a transfer that seems medically inappropriate. The physician is obliged to explain the medical risks involved, and an informed consent form should be signed by the patient (or those responsible for the patient) and the physician. In the event of such a transfer, the physician still should use every resource available in an attempt to stabilize the patient prior to transfer.

The following guidelines should be observed for transfer of patients:

1. The patient should be transferred to a facility that is appropriate to the medical needs of the patient. The facility should have adequate space and personnel available to care for the patient.

2. A physician or other responsible person at the receiving hospital must agree to accept the patient prior to the transfer taking place. Acceptable "other responsible persons" should be medical personnel who are designated by the hospital and given the authority to accept the transfer of the patient. The patient transfer should not be refused by the receiving hospital when the transfer is indicated and the receiving hospital has the capability and/or responsibility to provide care to the patient.

3. Communication between responsible persons at the transferring and receiving hospitals for purposes of exchanging clinical information should occur prior to transfer. Ideally this communication should take place between physicians.

4. Once a patient is accepted for transfer, an appropriate medical summary and other records (including laboratory results and copies of electrocardiograms, radiographs, and other diagnostic tests) should be sent with the patient.

5. A patient should be transferred in a vehicle that is staffed by appropriately trained personnel and that contains life-support equipment. It may be necessary for additional specialized personnel from the transferring or receiving hospital to accompany the patient.

Transfer of patients may occur routinely or as part of a regionalized plan for obtaining optimal care for patients at more appropriate and/or specialized facilities. In these situations, there should be the following:

1. Written guidelines to govern the transfer of patients (eg, types of cases that are appropriate for transfer);

2. Preexisting transfer agreements between the facilities; and

3. Pretransfer communication between appropriate responsible persons.

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August 5, 1987

Rep. Fortney Stark
Chairman
Subcommittee on Health
House Ways and Means Committee
1114 Longworth Building
Washington, DC 20515

Re: Patient Dumping

Dear Chairman Stark:

I am writing to express concern regarding current deficiencies in the enforcement of last year's Medicare amendments which prohibited hospitals from engaging in the practice of "patient dumping." I have previously been in contact with your staff regarding these enforcement problems and would like to use this letter to suggest a couple of amendments which might partially improve the present situation.

The recent oversight hearings before the Subcommittee on Human Resources and Intergovernmental Relations of the Government Operations Committee have documented the Health Care Financing Administration's failure to investigate and sanction instances of patient dumping which have occurred in violation of last year's legislation. The testimony of HCFA witnesses gave no assurance that they appreciate the seriousness of the problem and the urgency of the need for a vigorous new enforcement policy. Although the Congress should continue to encourage HCFA to properly discharge its enforcement responsibilities under the law, the experience of the past year suggests that administrative enforcement is likely to continue to be, at best, disappointing.

Although HCFA has done a poor job, and does not seem particularly motivated to do better, some of the limitations on effectiveness of administrative enforcement are inherent, and will always limit the effectiveness of the legislation. Witnesses from the large hospitals of last resort who are on the receiving end of the "patient dumping" process admitted at the hearing that they were aware of the administrative sanctions, but had still not filed complaints with HCFA against the responsible hospitals. The reality, as in most businesses and professions, is that it is difficult for one provider to inform on another. Thus, although the recent hearings established that patient dumping continues on a broad scale, only a very small part of the problem has been reported to the federal enforcement agency.

This record points to the need to amend the law to strengthen existing provisions authorizing private judicial enforcement. Subsection (d)(3) of Section 1867 of the Social Security Act (42 U.S.C. § 1396dd) already establishes a private right of action on behalf of any individual who suffers personal harm as a direct result of a Medicare-participating hospital's violation of the statute. In spite of the continuing practice of patient dumping, this provision, like the provisions authorizing administrative enforcement, appears not to have been used. Certainly the threat of civil enforcement appears to have had little, if any, deterrent effect.

I would respectfully suggest that the law be amended to provide for liquidated damages and an allowance of reasonable attorney's fees to prevailing plaintiffs.

Such amendments would address a couple of practical problems which account for the ineffectiveness of the current civil enforcement provision. These problems arise from common law rules governing civil recoveries in most states. For example, under the common law, lost wages are an important measure of compensatory damages. Yet the victims of patient dumping are typically poor people who are disabled, unemployed or working in low-wage jobs. They can therefore expect to recover little, if any, compensatory damages for financial loss.

The most serious weakness of the current law is its requirement that an unlawful transfer be proven to have directly caused a plaintiff's injury, in order for a court to grant relief against the wrongdoer. This is problematic, because most dumping victims are in poor medical condition *before* they become victims of an illegal transfer. By definition, such patients are already sick or injured. In the most egregious dumping cases, they are critically ill and unstable. If their medical condition subsequently deteriorates, or if they die, it can be extremely difficult to satisfy the current requirement of proof that the individual "suffer[ed] personal harm as a direct result of" the illegal transfer.

Who is to say, for example, that a trauma victim, or a person who has suffered a stroke, and who dies or is disabled following an illegal transfer, would not have suffered the same fate anyway? Although in some instances the case can be made, it will always be difficult and costly. Attorneys considering taking the case are likely to be deterred by the complexity of the medical proof that will be required, the cost of expert witnesses and trial preparation, and the fact that the attorney himself must advance these costs for a client who is, by definition, indigent and unable to pay them himself.

The difficulties of proving causation are compounded in the worst cases, where the victim of the illegal transfer is seriously disabled or even dead, and therefore unable to offer testimony himself.

Illegal transfers which recently occurred in Tennessee, and which have been the subject of previous communications with your staff, illustrate these problems. Both cases were discussed by witnesses testifying recently at the oversight hearings.

The first of these cases involved the death last September of a young man named Terry Takewell. Mr. Takewell, who had suffered from juvenile-onset diabetes, died at his home in Somerville, Tennessee within about 12 hours of having been dumped, almost literally, from Methodist Hospital of Somerville. Neighbors had found Terry at home suffering from acute ketoacidosis, and he had been transported by ambulance, first to a physician's office, and then to the hospital. The physician, who was familiar with Mr. Takewell's medical history, diagnosed the problem and ordered immediate emergency treatment. According to eyewitnesses, however, the acting hospital administrator personally took Mr. Takewell out of his hospital bed, and, holding him up under the arms, walked him out of the hospital and left him in the parking lot. He died that night at home, without having received the emergency treatment ordered by the physician. A witness was told by Mr. Takewell, and received confirmation from the hospital, that he was refused care because he had no insurance and still owed the facility for an earlier stay.

Mr. Takewell was described by a neighbor as a hard worker who did carpentry for a local contractor. However, his disease was so pernicious that he was often unable to work at all, and his earnings capacity was limited. The measure of damages in his case, under Tennessee law, could therefore be relatively small as a result. Moreover, since the tests ordered by the physician were never conducted by the hospital, it may prove difficult to establish that his condition at the time of denial of care was such that he could have survived even with adequate treatment. For these practical reasons, this egregious violation of the law, committed by a multi-facility chain which annually receives tens of millions of dollars of Medicare funds (not to mention favorable tax treatment as a "charitable" institution) may ultimately go unpunished in the courts.

Another example from Tennessee with which I am familiar is that of Mr. Clyde W. Lowe of Dickson, Tennessee. Mr. Lowe is also diabetic, and has been disabled for more than a decade with serious heart disease. In December of last year, he was evaluated by a staff physician at Goodlark

Hospital in Dickson, a proprietary facility which participates in the Medicare program. His heart was monitored for a period, and the physician then ordered his admission and treatment as an inpatient at Goodlark. However, the facility denied him treatment because of his inability to prepay his Medicare coinsurance or deductible amounts. (This is a violation of Medicare regulations, even apart from the anti-dumping statute. See 42 C.F.R. § 489.22) Nothing was done to stabilize his condition. The next day his family took him to another hospital, where he was admitted to the critical care unit through the emergency room. He spent several days in the hospital, and tests that were needed could not be done initially because his condition was so poor, due to the delay in hospitalization.

Fortunately, unlike Mr. Takewell, Mr. Lowe survived. However, it is difficult to prove that he suffered "personal harm as a direct result of" Goodlark's violation of the law. Certainly, he and his family experienced great anxiety between the time that he was dumped from Goodlark and finally admitted to another facility, and it is possible that he suffered physical pain during that period which might have been alleviated as an inpatient. Yet the speculative nature of such claims and the minimal amount of damages that could be obtained in the best of circumstances have made it impossible to find an attorney to bring a civil action on Mr. Lowe's behalf under the provisions of the current law. As a result, Goodlark continues to go unpunished for what could well have been a life-threatening transfer, and is presumably undeterred from continuing to engage in such practices in the future.

In light of these problems, it is reasonable to attach a liquidated penalty to any violation of the anti-dumping statute. Although there is no complete answer to these problems, the law would be significantly strengthened by insuring that a hospital which illegally transferred a patient faced the prospect of paying at least *some* form of monetary damage to the victim, even if the seriousness of the injury or the luck of the medical outcome precluded an award of substantial compensatory damages. There are ample precedents for such a remedy elsewhere in the law. For example, when Congress enacted Truth-in-Lending legislation, it recognized that there would often be credit abuses in which the victims would be unable to satisfy traditional common law requirements relating to proof of injury. Because Congress felt that it was nonetheless important to deter such abuses, it provided for liquidated damages as a means of making private civil enforcement effective. See 15 U.S.C. § 1640 *et seq.* The interests at stake in the case of patient dumping are certainly no less important than those which justified the award of liquidated damages for violations of federal Truth-in-Lending laws.

Any amendment providing for liquidated damages should explicitly reserve the plaintiff's right to recover compensatory and punitive damages where authorized by state law, as is the case under the present statute.

Even liquidated damages will be of little avail if there are no attorneys willing to vindicate the victim's rights. Since presumably even liquidated damages will be in an amount too small to support a contingent fee, it is important for the statute to authorize the award of reasonable attorney's fees to successful plaintiffs. There are, of course, already scores of similar fee-shifting provisions in the federal law, ranging from anti-trust to consumer protection to taxpayer appeals. Underlying these statutes is not only a recognition of the importance of attracting competent counsel, but also the belief that it is only fair to have the cost of vindicating federal rights borne by the wrongdoer, rather than by the victim.

Thank you for your consideration of these comments. As someone whose low-income clients face the denial of needed care on a daily basis, I very much appreciate your leadership on this important social and moral issue.

Sincerely yours,

Gordon Bonnyman

GGB:cj

Mr. **Weiss**. I simply want to state that I understand that you all take this issue very, very seriously, and I know that the Department has supported the legislation. I would only urge you that if you have reason to believe that the legislation that is on the books is not workable for whatever reason or needs correction to be more effective, that you respond quickly with that rather than waiting for as long a period of time as has elapsed thus far. As you know better than anybody else, literally the lives of great numbers of Americans are at stake in this whole issue. I think that there is and should be a greater sense of urgency in our dealing with it.

In this hearing we have been discussing the real life and death issues of people's lives. Access to health care should be available to everyone regardless of their economic status. But we have heard of case after case of denial of services to persons who are poor and, all to frequently, minority.

Congress has repeatedly demonstrated its concern with the problem of access to health care, and in the case of dumping of patients, has directed that the administration take strong and immediate action to stop it. Congressman Pete Stark's amendment was the most recent and important vehicle.

But the success of a provision such as the anti-dumping law depends not only on rigorous enforcement, but equally on the perception by doctors and hospitals of strong enforcement and penalties, as well as on a broad campaign to educate patients of their rights under the law. Thus far we could hardly say that the administration has met the challenge.

In fact, there has been an inexcusable delay by the Department of Health and Human Services in implementing and enforcing this statute. Processing of the few complaints that have been received by HHS has been, at best, slow. Implementing regulations have not been published in the 15 months since the law was enacted, nor has there even been a resolution to the problem of overlapping authorities and activities worked out among the various offices involved.

At a time when we are all concerned with efficiency and minimizing paperwork burdens, there can be no excuse for duplication of investigative activities. The most capable office should get the responsibility. One office should have enforcement authority for a sanction. But it must be selected on the basis of which one will do the best job of deterring further violations of the law.

The subcommittee intends to continue to monitor the Department's implementation of this important law. For the sake of patients, let's get on with it.

Again, I thank you for your participation. The subcommittee now stands adjourned, subject to the call of the Chair.

[Whereupon, at 4:50 p.m., the subcommittee adjourned, to reconvene subject to the call of the Chair.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

Attachment

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA) (P.L. 99-272)

Title IX - Medicare, Medicaid, and Maternal and Child Health Programs

Subpart B—Miscellaneous Provisions

SEC. 9121. RESPONSIBILITIES OF MEDICARE HOSPITALS IN EMERGENCY CASES.

(a) REQUIREMENT OF MEDICARE HOSPITAL PROVIDER AGREEMENTS.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(1) by striking out "and" at the end of subparagraph (G),

(2) by striking out the period at the end of subparagraph (H) and inserting in lieu thereof ", and", and

(3) by inserting after subparagraph (H) the following new subparagraph:

"(I) in the case of a hospital, to comply with the requirements of section 1867 to the extent applicable.".

(b) REQUIREMENTS.—Title XVIII of such Act is amended by inserting after section 1866 the following new section:

"EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN ACTIVE LABOR

"SEC. 1867. (a) MEDICAL SCREENING REQUIREMENT.—In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists or to determine if the individual is in active labor (within the meaning of subsection (e)(2)).

"(b) NECESSARY STABILIZING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND ACTIVE LABOR.—

"(1) IN GENERAL.—If any individual (whether or not eligible for benefits under this title) comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide either—

Attachment

"(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor, or

"(B) for transfer of the individual to another medical facility in accordance with subsection (c).

"(2) REFUSAL TO CONSENT TO TREATMENT.—A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph but the individual (or a legally responsible person acting on the individual's behalf) refuses to consent to the examination or treatment.

"(3) REFUSAL TO CONSENT TO TRANSFER.—A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) but the individual (or a legally responsible person acting on the individual's behalf) refuses to consent to the transfer.

"(c) RESTRICTING TRANSFERS UNTIL PATIENT STABILIZED.—

"(1) RULE.—If a patient at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(4)(B)) or is in active labor, the hospital may not transfer the patient unless—

"(A)(i) the patient (or a legally responsible person acting on the patient's behalf) requests that the transfer be effected, or

"(ii) a physician (within the meaning of section 1861(r)(1)), or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer; and

"(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

"(2) APPROPRIATE TRANSFER.—An appropriate transfer to a medical facility is a transfer—

"(A) in which the receiving facility—

"(i) has available space and qualified personnel for the treatment of the patient, and

"(ii) has agreed to accept transfer of the patient and to provide appropriate medical treatment;

"(B) in which the transferring hospital provides the receiving facility with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital;

"(C) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

"(D) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of patients transferred.

"(d) ENFORCEMENT.—

"(1) AS REQUIREMENT OF MEDICARE PROVIDER AGREEMENT.—If a hospital knowingly and willfully, or negligently, fails to meet the requirements of this section, such hospital is subject to—

"(A) termination of its provider agreement under this title in accordance with section 1866(b), or

"(B) at the option of the Secretary, suspension of such agreement for such period of time as the Secretary determines to be appropriate, upon reasonable notice to the hospital and to the public.

Attachment

"(2) Civil monetary penalties.—In addition to the other grounds for imposition of a civil money penalty under section 1128A(a), a participating hospital that knowingly violates a requirement of this section and the responsible physician in the hospital with respect to such a violation are each subject, under that section, to a civil money penalty of not more than $25,000 for each such violation. As used in the previous sentence, the term 'responsible physician' means, with respect to a hospital's violation of a requirement of this section, a physician who—

"(A) is employed by, or under contract with, the participating hospital, and

"(B) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred.

"(3) Civil enforcement.—

"(A) Personal harm.—Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

"(B) Financial loss to other medical facility.—Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

"(C) Limitations on actions.—No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

"(e) Definitions.—In this section:

"(1) The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

"(A) placing the patient's health in serious jeopardy,

"(B) serious impairment to bodily functions, or

"(C) serious dysfunction of any bodily organ or part.

"(2) The term 'active labor' means labor at a time at which—

"(A) delivery is imminent,

"(B) there is inadequate time to effect safe transfer to another hospital prior to delivery, or

"(C) a transfer may pose a threat of the health and safety of the patient or the unborn child.

"(3) The term 'participating hospital' means hospital that has entered into a provider agreement under section 1866 and has, under the agreement, obligated itself to comply with the requirements of this section.

"(4)(A) The term 'to stabilize' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condi-

tion is likely to result from the transfer of the individual from a facility.

"(B) The term 'stabilized' means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from a facility.

"(5) The term 'transfer' means the movement (including the discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of a patient who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

"(f) Preemption.—The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.".

(c) Effective Date.—The amendments made by this section shall take effect on the first day of the first month that begins at least 90 days after the date of the enactment of this Act.

(d) Report.—The Secretary of Health and Human Services shall, not later than 6 months after the effective date described in subsection (c), report to Congress on the methods to be used for monitoring and enforcing compliance with section 1867 of the Social Security Act.

(4)

Health Care
Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

(4)

Date . JUN 4 1987

From Director
Health Standards and Quality Bureau

Subject: Interim Instructions for Implementing Section 1867 of the Social Security Act; Responsibilities of Medicare Hospitals in Emergency Cases

To Regional Administrators
Region I - X

Purpose

There has been considerable discussion and coordination between central and regional office staff on the "anti-dumping" provisions of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA). The purpose of this memorandum is to provide more formal direction and assure uniformity in our enforcement action.

Background

COBRA added a new section to the Social Security Act: Section 1867 - Responsibilities of Medicare Hospitals in Emergency Cases. That section, effective August 1, 1986, requires that participating hospitals with emergency departments provide, upon request, and within the hospital's capabilities, medical screening examinations and treatments for women in active labor and individuals (including non-Medicare beneficiaries) with emergency medical conditions, or to arrange appropriate transfer of the patient to another medical facility unless the patient or the legal representative of the patient refuses treatment or transfer.

Hospitals that knowingly, willfully or negligently fail to comply with the requirements of this legislation are subject to termination or suspension of their Medicare provider agreements. Hospitals are also subject to civil monetary penalties of up to $25,000 for each violation of these provisions, as are the responsible physician or physicians. In addition, individuals suffering personal harm and medical facilities suffering financial loss as a result of a violation of these provisions can bring civil action under State law against the offending hospital.

Interim Operating Instructions

The primary impetus to taking action under Section 1867 is a complaint. Therefore, a complaint should trigger the following actions by the Region:

- Send the complainant a letter acknowledging receipt of the allegation (investigation warranted, Tab A; investigation not warranted, Tab B). Please note that this letter informs the complainant of the right to pursue independent civil action.

- Notify the applicable Peer Review Organization (PRO) of the complaint investigation for its own information.

- Direct the State agency (SA) to conduct at least a limited survey to investigate the complaint within 5 working days. Although you may require a full survey, the minimum conditions of participation to be surveyed are:

    - emergency services
    - medical staff

- Tell the SA to call you immediately, from the hospital, if the surveyors need professional medical assistance during the survey. If the medical issues present are beyond the expertise of the SA, you may seek it from the PRO, State physician consultants or regional office physician staff.

    - The PRO will be reimbursed for all reasonable and necessary costs.

    - Instruct the PRO to provide a written evaluation to you within 5 working days of all cases referred for investigation.

- Direct the SA to provide you with the results of the survey and its recommendations by overnight mail within two days following completion of the onsite survey.

- Evaluate the SA and, when appropriate, PRO findings. If the results indicate the hospital is out of compliance with one or more conditions of participation which results in patients being "dumped," that is, transferred or otherwise discharged in an unstable medical condition, initiate a fast track termination. The rationale for this action is that obviously the hospital is taking actions or not taking actions which result in an immediate threat to the health and safety of patients.

- If the hospital alleges correction before the effective date of termination, direct the SA to resurvey for the condition(s) of participation you had determined to be out of compliance.
- If the condition(s) remains out of compliance, let the termination take effect.
- If the hospital has corrected its problem(s):
    - be sure the remedy is good for the long term and that the hospital is providing reasonable assurance through its actions that such violations will not take place again;
    - remove the hospital's "deemed status" and place it under state agency monitoring.
    - ensure that a resurvey takes place within 60 days.
- If the termination takes place, you should demand, as a condition for participation in Medicare, that a hospital has no cases of "dumping" for at least 30 days prior to the onsite survey. This should be determined through a rigorous review of emergency room records as well as staff interviews during the onsite survey.
- Any case of confirmed "dumping," whether you terminate or not, should be referred to the Office of the Inspector General (OIG) for potential civil monetary penalties.
- Send the complainant a letter reporting the final results of the investigation.

Future Actions

These interim instructions represent actions already taken by a number of Regional Offices in close cooperation with HSQB and OIG. We will be issuing formal instructions through the HCFA Issuance System in the near future. Furthermore, regulations on suspending provider agreements and other relevant amendments of current rules will be published as proposed rules.

If you have any questions on these interim instructions do not hesitate to contact me.

Thomas G. Morford

Any contacts

Attachments: Tabs A and B

cc: Deputy AAO

TAB A

MODEL LETTER ACKNOWLEDGING COMPLAINT ALLEGING NONCOMPLIANCE WITH THE EMERGENCY CARE REQUIREMENTS OF SECTION 1867 OF THE SOCIAL SECURITY ACT

INVESTIGATION NOT WARRANTED

(Name)
(Address)

Dear ______________:

We have reviewed the information you provided concerning (hospital, city, state), and appreciate the interest you have shown in bringing this matter to our attention. Enclosed please find a copy of the law for your information. Our responsibility is to assure compliance of Medicare participating hospitals with the health care safety requirements of the law.

We have not authorized any further investigation of your complaint. Our review does not find that the situation that you describe indicates any violation of the law. Based on your individual situation, however, you may wish to consider the Civil Enforcement provisions of the law on an independent basis.

Again, we appreciate your bringing this matter to our attention.

Sincerely yours,

Associate Regional Administrator
for Health Standards and Quality

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration
42 CFR Part 489
[BERC-393-P]

4/21/87

MEDICARE PROGRAM

Participation in CHAMPUS and CHAMPVA, Hospital Admissions for Veterans, Discharge Rights Notice, and Hospital Responsibility for Emergency Care

AGENCY: Health Care Financing Administration (HCFA), HHS

ACTION: Proposed rule.

SUMMARY: We are proposing to revise requirements for Medicare participating hospitals by adding the following:

- A hospital must provide inpatient hospital services to individuals who have health insurance coverage provided by either the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or the Civilian Health and Medical Program of the Veterans Administration (CHAMPVA), subject to limitations provided by regulations, and accept the CHAMPUS/CHAMPVA-determined allowable amount as payment in full for the services.
- A hospital must provide inpatient hospital services to military veterans (subject to the limitations provided in 38 CFR 17.50 ff.) and accept payment from the Veterans Administration as payment in full.

- A hospital must give each beneficiary a notice of his or her rights concerning discharge from the hospital.
- A hospital with an emergency department must provide, upon request and within the capabilities of the hospital, an appropriate medical screening examination and stabilizing treatment to any individual with an emergency medical condition and to any woman in active labor, regardless of the individual's eligibility for Medicare.

We would provide for the termination of a provider's agreement for violation of any of these provisions. In addition, we would provide for the suspension of a provider's agreement (rather than termination) and for civil monetary penalties for violation of the emergency care provision.

These revisions would implement sections 9121 and 9122 of the Consolidated Omnibus Budget Reconciliation Act of 1985, section 233 of the Veteran's Benefit Improvement and Health Care Authorization Act of 1986, and section 9305(b)(1) of the Omnibus Budget Reconciliation Act of 1986.

DATE: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5:00 p.m. on [60 days after the date of publication].

ADDRESS: Mail comments to the following address:

Health Care Financing Administration
Department of Health and Human Services
Attention: BERC-393-P
P.O. Box 26676
Baltimore, Maryland 21207

If you prefer, you may deliver your comments to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building
200 Independence Ave., SW.
Washington, D.C., or

Room 132, East High Rise Building
6325 Security Boulevard
Baltimore, Maryland.

In commenting, please refer to file code BERC-393-P.

Comments received timely will be available for public inspection as they are received, which generally begins about three weeks after publication of a document, in Room 309-G of the Department's offices at 200 Independence Ave., SW., Washington, D.C., on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (phone: 202-245-7890).

FOR FURTHER INFORMATION, CONTACT:

Thomas Hoyer 301-594-9446	For all provisions except civil monetary penalties.
Joel Schaer 202-472-5270	For provisions relating to civil monetary penalties.

SUPPLEMENTARY INFORMATION:

I. Background

A. Participation in the CHAMPUS and CHAMPVA programs

CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) and CHAMPVA (Civilian Health and Medical Program of the Veterans Administration) programs pay for health care services furnished to dependents and survivors of military personnel and of veterans. Generally, the programs have paid hospitals based on their charges. Section 931 of the Department of Defense Authorization Act, 1984 (Pub. L. 98-94) authorized these programs to pay (to the extent practicable) for inpatient hospital services using Medicare reimbursement procedures, which usually pay less than billed charges. Because the Medicare prospective payment system (PPS) (the system whereby we pay a hospital a predetermined amount based on the patient's diagnosis and any surgical procedures performed, rather than by the number of days hospitalized) results in Medicare cost savings, the Department of Defense (DoD) expects that it would realize similar savings if it were to use a model similar to Medicare's PPS. In fact, the Office of Civilian Health and Medicare Program of the Uniformed Services (OCHAMPUS) has plans already underway to use a reimbursement system modeled after Medicare's PPS that has been modified specifically for the CHAMPUS program (e.g. using CHAMPUS-specific weights and rates). DoD also would realize savings by paying "reasonable cost" where necessary. We understand that there is a feasibility study under way and that the DoD is considering revising its regulations.

Hospitals that furnish services to CHAMPUS and CHAMPVA beneficiaries are authorized provide services to these beneficiaries following an approval process similar to that used for Medicare participation. All hospitals certified by the Joint Commission on Accreditation of Hospitals (JCAH) are authorized providers; any Medicare hospital may be (and all have been thus far) deemed to be authorized providers. All others are surveyed by OCHAMPUS to determine whether they are authorized providers.

"Participation" has a different meaning for CHAMPUS and CHAMPVA than for Medicare: providers have been able to decide on a case-by-case basis whether to "participate" in the program and thus accept the CHAMPUS/CHAMPVA-determined allowable amount as payment in full (under these programs, beneficiaries are required to pay a cost-share for each hospital admission, and this is considered to be separate from the CHAMPUS/CHAMPVA payment). Under Medicare, hospitals must agree to bill the program for all beneficiaries and accept Medicare payment as payment in full (less applicable deductibles, coinsurance amounts, and noncovered items).

As indicated above, all Medicare hospitals are also authorized providers in CHAMPUS and CHAMPVA on the basis of their JCAH-approved status or are deemed authorized providers based on their Medicare-approved status. The benefits to the DoD of requiring them to be paid either under a DRG-based payment system or based on reasonable cost are lost, however, if the hospitals can selectively participate in the CHAMPUS and CHAMPVA programs. Congress, in section 9122 of COBRA, now requires all Medicare hospitals, beginning January 1987, to participate in CHAMPUS or CHAMPVA as authorized providers (i.e., they must bill CHAMPUS or CHAMPVA and accept the CHAMPVA/CHAMPUS-determined allowable amount as payment in full.

B. Participation in the Veterans Administration (VA) Health Care Program

A veteran with a service-connected disability is not required to use Veterans Administration (VA) hospitals but may elect to receive services from "civilian" providers and be reimbursed through CHAMPUS. However, once the VA has made or has authorized payment for services related to a service-connected disability, the veteran must obtain all services through the VA. In cases where the veteran receives services from a non-VA hospital, either through choice or because there is no available VA hospital which can provide the necessary services, the VA pays for the services based on the hospital's charges.

As with CHAMPUS and CHAMPVA, which also paid the hospital's charges, this type of payment is more expensive than payment on a prospective basis or based on reasonable costs. As a result, the VA is setting up a national prospective payment system.

To alleviate hospital expenses for the VA, Congress passed section 233 of the Veterans' Benefit Improvement and Health-Care Authorization Act of 1986 (Pub. L. 99-576). This section requires Medicare hospitals to be participating providers of medical care to veterans eligible to receive care at the hospital. The hospital then would receive payment for the services under the applicable VA payment system, rather then simply on the basis of the hospital's charges.

C. Statement of beneficiary rights

After the prospective payment system became effective for the Medicare program, we began to hear allegations that Medicare beneficiaries were discharged too early from the hospital and we also began to receive complaints that patients did not understand their rights as Medicare beneficiaries in cases where they were advised that discharge was appropriate but disagreed. In response, we began requiring hospitals to furnish each beneficiary upon admission a notice telling a beneficiary of his rights to be fully informed about decisions affecting Medicare coverage or payment and about appeal rights in response to any written notices to the effect that Medicare will no longer cover the care. The notice we developed also advises the patient what to do and how to elicit more information. The requirements relating to the notice were incorporated into the program's operating instructions; however, until enactment of the Omnibus Budget Reconciliation Act of 1986 (OBRA 86), there was no statutory requirement for such a notice and no regulations relating to it.

In order to provide a statutory ratification of our administrative requirement for hospitals to furnish a notice of the beneficiary's discharge rights, Congress passed section 9305(b) of the Omnibus Budget Reconciliation Act of 1986 (OBRA 86). Now, as part of its participation agreement with Medicare, each hospital must agree to furnish each Medicare beneficiary with a notice, at or about the time of admission, that explains the patient's rights.

D. Responsibilities of Medicare participating hospitals in emergency cases

Hospitals that choose to participate in the Medicare program agree in writing to meet various requirements included in section 1866 of the Social Security Act (the Act). Before enactment of Pub L. 99-272 on April 7, 1986, the Act did not specifically address the issue of how hospitals with emergency medical departments must handle individuals who have emergency medical conditions or who are in active labor.

In its Report accompanying H.R. 3128, the House Ways and Means Committee indicated that Congress was concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions, including medically unstable patients, if the patients do not have medical insurance. In addition, the Report stated that there have been reports that patients in an unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital. Because Congress believed that this situation may have worsened since the Medicare prospective payment system for hospitals became effective, the Report states that it "wants to provide a strong assurance that pressures for greater hospital efficiency are not to be construed as license to ignore traditional community responsibilities and loosen historic standards." (H.R. Rep. No. 99-241, 99th Cong., 1st Sess. 27 (1985).) As a result of this concern, Congress enacted section 9121 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, Pub. L. 99-272.

II. Legislation

A. Participation in CHAMPUS and CHAMPVA programs

Section 9122 of COBRA amended section 1866(a)(1) of the Act by adding a new paragraph (J), which requires hospitals in the Medicare program to be participating providers of medical care, for inpatient services only, under any health plan contracted for under 10 U.S.C.1079 or 1086 (CHAMPUS) or under 38 U.S.C. 613 (CHAMPVA), in accordance with admission practices and payment methodology and amounts as prescribed under joint regulations issued by the Secretaries of Health and Human Services, Defense and Transportation. This requirement applies to services furnished to CHAMPUS and CHAMPVA beneficiaries admitted on or after January 1, 1987.

(Section 9122 of COBRA also required that the legislation apply to all agreements entered into on or after April 7, 1986, but this requirement was deleted by section 1895 (b)(6) of the Tax Reform Act of 1986 (Pub.L. 99-514), enacted October 22, 1986.)

B. Participation in the Veterans Administration Health Care Program

Section 233 of the Veterans' Benefit Improvement and Health-Care Authorization Act of 1986 (Pub. L.. 99-576) was enacted on October 28, 1986. It added a new paragraph (L) to section 1866 (a)(1) of the Act. It requires hospitals that participate in Medicare to be participating providers under 38 U. S. C. 603, in accordance with the admissions practices, and payment methodology and amounts, prescribed under joint regulations issued to implement this section by the Secretary of HHS and the Administrator of the VA. This provision applies to services furnished to veterans admitted on or after July 1, 1987.

C. Statement of beneficiary rights

The Omnibus Budget Reconciliation Act of 1986 (OBRA 86) was enacted on October 21, 1986. Section 9305(b)(1) of OBRA 86 adds a new paragraph (M) to section 1866(a)(1) of the Act. That paragraph requires a hospital that is eligible to participate in the Medicare program to agree to furnish, upon admission, a beneficiary, or an individual acting on his or her behalf, with a written statement of the beneficiary's discharge rights. The statement must explain:

(1) The individual's rights to benefits for inpatient hospital services and for posthospital services under Medicare;

(2) The circumstances under which the beneficiary will and will not be liable for charges for continued stay in the hospital;

(3) The beneficiary's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate the appeal;

(4) The individual's liability for services if the denial of benefits is upheld on appeal; and

(5) Additional information that the Secretary specifies.

Section 9305(b)(2) of OBRA 86 requires that we prescribe the language to be used in the notice not later than six months after the effective date of OBRA 86 (i.e., by April 21, 1987). Hospitals must begin complying with the requirement to give the statement to beneficiaries upon admission no later than 60 days after we prescribe the language to be used.

D. Responsibilities of Medicare participating hospitals in emergency cases

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 was enacted on April 7, 1986. Section 9121 prohibits hospitals with emergency medical departments from refusing to treat medically unstable patients. It also contains provisions designed to halt the inappropriate transfers of these patients to other medical facilities.

Section 9121 of COBRA added a paragraph (I) to section 1866(a)(1) of the Act and added a new section 1867 to the Act. Section 1866(a)(1)(I) requires that a hospital participating in the Medicare program must agree to comply with the requirements of section 1867 of the Act to the extent applicable. Section 1867 provides the following:

(a) A hospital with an emergency department must, within the capabilities of its emergency department, provide an appropriate medical screening examination to any individual who comes to the emergency department for examination or treatment of a medical condition and on whose behalf the examination or treatment is requested; the purpose of the examination is to determine whether the individual has an emergency medical condition or is in active labor. This requirement applies regardless of the individual's eligibility for Medicare benefits.

(b) If an individual, regardless of eligibility for Medicare benefits, has an emergency medical condition or is in active labor, the hospital must either provide for further examination and treatment (within its capabilities) or make an appropriate transfer of the patient to another medical facility, unless the treatment or transfer is refused.

(c) A hospital may not transfer a patient unless --

(1) (A) He or she, or a legally responsible person acting on his or her behalf, requests the transfer, or (B) a physician, or other qualified medical personnel when a physician is not readily available, has certified that the medical benefits expected from the treatment at the new facility outweigh the increased risks to the patient's condition resulting from the transfer; and

(2) The transfer is an "appropriate transfer", as defined below.

An "appropriate transfer" is a transfer: (1) in which the receiving facility has available space and qualified personnel for the treatment of the patient and has agreed to accept the transfer and to provide appropriate medical treatment; (2) in which the transferring hospital provides the receiving facility with appropriate medical records (or copies) of the examination and treatment furnished at the transferring hospital; (3) in which the transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer; and (4) that meets other requirements as the Secretary may find necessary in the interest of the health and safety of the patient.

(d) A hospital that knowingly and willfully, or negligently, fails to meet the requirements of section 1867 of the Act--

(1) Is subject to termination of its Medicare agreement or, at the option of the Secretary of the Department of Health and Human Services

(HHS), suspension of the Medicare agreement. The suspension is subject to reasonable notice to the hospital and public and is for a duration that the Secretary determines to be appropriate; and

(2) Is also subject to civil monetary penalties (which are in addition to those provided under section 1128A of the Act). The penalty cannot exceed $25,000 for each violation. The responsible physician or physicians are also subject to a civil money penalty of not more than $25,000 for each violation.

"A responsible physician" is a physician within the meaning of section 1861(r)(1) of the Act (doctor of medicine or osteopathy) who is employed by, or under contract with, the participating provider and acting as such has professional responsibility for the provision of examination or treatment of the individual, or transfer of the individual.

(e) If a hospital knowingly, willfully or negligently violates the requirements of section 1867 and a patient suffers personal harm as a direct result, he or she may, in a civil action against the participating hospital, obtain damages for personal injury under the law of the State in which the hospital is located and may obtain such equitable relief as is appropriate.

(f) Any medical facility that suffers a financial loss as a direct result of a participating hospital's knowing, willful or negligent violation of section 1867 may obtain damages available in a civil action against the participating hospital, under the law of the State in which the hospital is located, and may obtain such equitable relief as is appropriate.

(g) No civil action under (e) and (f) above may be brought more than two years after the date of the violation with respect to which the action is brought.

(h) Section 1867 also contains definitions of several other terms: "emergency medical condition," "participating hospital," "active labor," "to stabilize," "stabilized," and "transfer."

(i) The provisions of section 1867 do not preempt any State or local law except where they directly conflict.

Provisions of the Proposed Regulations

A. Participation in CHAMPUS and CHAMPVA programs

We would revise §489.20, Basic commitments, to show that a participating Medicare hospital must agree to participate in the CHAMPUS and CHAMPVA programs and accept the CHAMPUS/CHAMPVA-determined allowable amount as payment in full in accordance with a new §489.25, which incorporates statutory provisions.

In a new section, 42 CFR 489.25, we would require Medicare participating hospitals to be participating providers in the CHAMPUS and CHAMPVA programs. We would require the hospitals to comply with Department of Defense regulations governing admissions practices and payment methodology and amounts for such services. (Those regulations would be issued jointly by the Secretaries of Defense, Transportation and Health and Human Services; CHAMPUS is developing the joint regulations.) We would continue the policy that hospitals participating in CHAMPUS and CHAMPVA that also participate in Medicare must meet all Medicare conditions of participation. Thus, if CHAMPUS or CHAMPVA has requirements for participating that differ from Medicare's, Medicare's requirements would have to be met.

We would require hospitals to accept the CHAMPUS/CHAMPVA-determined allowable amount as payment in full for the services provided to these beneficiaries.

In addition, we would add a new paragraph (14) to §489.53, Terminations by HHS, to show that a hospital that does not meet the requirements of §489.25 would be subject to possible termination. We do not anticipate that Medicare participating hospitals will refuse to accept CHAMPUS or CHAMPVA beneficiaries under these proposed requirements. Should one do so, we would expect appropriate officials from the Department of Defense or Transportation to notify us and we would then discuss the issue with the hospital in hopes of resolving it. If it cannot be resolved, the HCFA regional office would terminate the hospital's provider agreement under the provisions of 42 CFR Part 489, Subpart E, since the hospital's refusal to participate in the CHAMPUS or CHAMPVA programs would violate 42 CFR §489.25 of these regulations.

These revisions would apply only to inpatient hospital services furnished to beneficiaries admitted on or after January 1, 1987.

B. Participation in the Veterans Administration Health Care Program

To implement section 233 of Pub. L. 99-576, we propose to add a new §489.26. Hospitals do not enter into participation agreements with the Veterans Administration program as they do if they choose to participate in the Medicare program or the CHAMPUS or CHAMPVA programs. Instead, the VA authorizes payment for the treatment, usually on a pre-admission basis at a designated hospital that furnishes the service. We would require a Medicare participating hospital to admit any veteran whose hospitalization is authorized by the VA under 38 U.S.C. 603 (this includes emergency cases, which may be authorized after admission). The hospital would have to meet the requirements of 38 CFR Part 17 regarding admission practices and payment methodology and amounts. This arrangement would not affect the hospitals' need to meet all Medicare hospital conditions of participation.

We would also revise §489.20, Basic commitments, to require hospitals to admit veterans whose admission is authorized under 38 U.S.C. 603 and to meet the requirements of §489.26.

We would also revise §489.53, Termination by HCFA, to show that HHS may terminate any hospital that fails to meet the requirements of §489.26. This would be included with the paragraph (14) requiring hospitals to participate in CHAMPUS and CHAMPVA.

As with the CHAMPUS and CHAMPVA programs, we do not anticipate that Medicare participating hospitals will resist the requirement to admit veterans. Should one do so, we would expect the appropriate official of the Veterans Administration to notify us and we would then discuss the issue with the hospital in hopes of resolving it. If it cannot be resolved, the HCFA regional office would terminate the hospital's provider agreement under the provisions of 42 CFR Part 489, Subpart E, since the hospital's refusal to admit veterans violates 42 CFR §489.26 of these regulations.

The VA is developing the regulations necessary to implement the statute (e.g., regarding payment methodology).

These regulations would apply to services furnished to veterans admitted on or after July 1, 1987.

C. Statement of beneficiary rights

We would add a new section, 42 CFR 489.27, to require participating hospitals that furnish inpatient hospital services to Medicare beneficiaries to give every beneficiary (or individual acting on his or her behalf) at or around the time of admission the notice prescribed by HHS concerning discharge rights. We would not specify the contents of the notice in these regulations, as the hospital will not be responsible for writing the notice; we will distribute to the hospitals the notice that the hospitals are to use.

We expect the notice of beneficiary rights to be available before this rule becomes final. The law is self-implementing, and it requires the language for the beneficiary notice to be prescribed within six months of the enactment of the legislation (i.e., by April 21, 1987) and it must be distributed by hospitals within two months after it is prescribed. This rule would merely conform the regulations to the statute.

We have revised our earlier notice, "An Important Message from Medicare," to incorporate the statutory requirements and have solicited comments from major beneficiary and provider organizations, such as the Gray Panthers, the American Hospital Association and the American Association of Retired Persons. We have also sent the notice to both the Senate and House Select Committees on Aging. The input from the various entities will be valuable in determining the final version of the notice.

We would also revise §489.20, Basic commitments, to show that a hospital must distribute the prescribed notice of discharge rights.

We would add a new paragraph (15) to §489.53, Terminations by HHS, to show that a hospital *failing* to meet the requirements of §489.27 may be terminated. Whether or not HHS would terminate a provider would depend on HCFA's judgement as to the scope of the failure and the hospital's correction or plan for correction of the failure. We do not anticipate any hospital opposition to the requirement that the notices be distributed. We believe we already have full cooperation from hospitals.

These revisions would apply only to Medicare admissions beginning 60 days or more after we have distributed the the necessary language. Hospitals may, however, begin to distribute it as soon as they receive their supply.

D. Hospital Emergency Care

[illegible]

The revisions to the regulations we are proposing would be revisions and additions to 42 CFR Part 489, Provider Agreements under Medicare, and revisions to 42 CFR Part 1003, Civil Money Penalties and Assessments. Basically, the provisions would parallel the statute.

1. We would revise 42 CFR 489.20, which discusses basic commitments, by adding a new paragraph to require hospitals as part of their participation to agree to

comply with the new §489.24, which incorporates the statutory requirements.

2. We would add a new section 489.24, Special responsibilities of Medicare hospitals in emergency cases, to set forth requirements for all hospitals that have provider agreements with Medicare. We would require a hospital to take the following measures.

a. Medical screening requirement

For any individual for whom emergency treatment or examination is requested, we would require a hospital with an emergency department to provide for an appropriate medical screening examination within the emergency department's capability to determine whether an emergency medical condition, as defined below, exists or whether the individual is in active labor. The examinations would have to be conducted by individuals qualified to conduct these examinations based on training and experience obtained in hospital emergency departments.

We would allow hospitals maximum flexibility in their utilization of emergency care personnel by not including specific requirements concerning education or credentials for individuals conducting emergency medical examinations. This policy is consistent with the specified intent of the recently revised conditions of participation (51 FR 22010; 42 CFR Part 482). We believe that a hospital's risk management program and the potential liability involved in the use of other than fully qualified and trained personnel would assure proper utilization of medical personnel.

b. Necessary stabilizing treatment for emergency medical conditions and active labor

If the individual has an emergency medical condition or is in active labor, the hospital would have to either provide further medical examination and treatment to stabilize the medical condition or treatment of the labor or transfer the individual appropriately to another medical facility. We would not hold the hospital responsible if the individual, or a legally responsible person acting on the individual's behalf, refuses to consent to the further examination and treatment or the appropriate transfer to another hospital.

c. Transfers and restrictions

If an individual at a hospital has an emergency medical condition that has not been stabilized or the individual is in active labor, the hospital could not transfer the individual unless one of the following conditions exist:

° The individual (or a legally responsible person on the individual's behalf) requests the transfer.

° A physician (or other qualified medical personnel if a physician is not readily available in the emergency department) has certified in writing that, based upon the reasonable risks and benefits to the individual and the information available at the time the medical benefits reasonably expected from the provision of appropriate medical treatment at the other facility outweigh the increased risks to the individual's medical condition from the transfer.

We would consider a transfer to be appropriate only if the receiving medical facility has available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the individual and to provide appropriate medical treatment. The transferring hospital would have to furnish the receiving medical facility with timely appropriate medical records (or copies) of the examination and treatment provided by the transferring hospital. The patient would have to be accompanied by qualified personnel during the transfer; transportation arrangements would have to include the use of necessary and medically appropriate life support measures.

Although the statute authorized the Secretary to find that the transfer must meet "other requirements" in the interest of the health and safety of patients transferred, we are not at this time proposing to adopt any. We do however specifically invite public comment concerning any "other requirements" the Secretary should consider adopting regarding the health and safety of emergency department patients being transferred between medical facilities.

d. Definitions

We would include in 42 CFR 489.24 the following definitions as defined in the statute, without interpretation:

- "Active labor" means labor at a time when delivery is imminent, there is inadequate time to effect safe transfer to another hospital before delivery, or a transfer may pose a threat to the health and safety of the patient or the unborn child.
- An "emergency medical condition" means a medical condition manifested by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious disfunction of any bodily organ or part.

- "To stabilize" means, with respect to an emergency medical condition, to provide the medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.
- "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of an individual from a facility.
- "Transfer" means the movement (including the discharge) of a patient to outside a hospital's facilities at the direction of any person employed by (or affiliated or associated with, directly or indirectly) the hospital, but it does not include moving a patient who has been declared dead or who leaves the facility without the permission of any person responsible for directing transfers.

We would not define "participating provider" in Part 489. This is because 42 CFR 400.202 defines terms applicable to all of 42 CFR Chapter IV and already defines "provider". A provider by definition agrees to participate in Medicare. The agreement is written and requires the provider to fulfill certain obligations. Until December 1986, the agreement required providers to meet only certain requirements of the Act as part of their provider agreement. In December, though, we sent out revised provider agreements for all participating hospitals to sign, indicating their agreement to comply with section 1866 of the Act in its entirety, so that they agree to meet the requirements of treating or transferring emergency patients and women in active labor. (Although not all agreements have been returned signed to us, section 1895(b)(4) of the Tax Reform Act of 1986 (Pub. L. 99-509) amended section 1867(e)(3) of the Act so that providers did not have to agree specifically to comply with section 1867; by agreeing to participate under the terms of the old agreements, the hospitals obligated themselves to comply with the requirements of section 1867.)

We would add a definition of "participating provider" and the remaining statutory definition.

that of "responsible physician", to 42 CFR Chapter V (Part 1003), since these terms are used in conjunction with monetary penalties, which is under the jurisdiction of the Office of the Inspector General. We discuss the definition of "responsible physician" below under "Civil Monetary Penalties."

We invite public comment regarding all definitions.

3. We propose to amend 42 CFR Parts 489 and 1003 to provide for types of sanctions that would be applied by the Department, as appropriate:

a. Termination or suspension of the provider agreement

If a hospital knowingly and willfully, or negligently, fails to provide the appropriate screening and treatment or transfer as explained above, it would be subject to termination or suspension of its provider agreement under section 1866(b) of the Act, as determined by HCFA (the authority to terminate has been delegated from HHS through the Administrator of HCFA to HCFA Regional

Offices). This requirement would be in §489.24 as paragraph (e). [Whether the hospital would be subject to termination or suspension would depend on whether, in HCFA's judgment, the preponderance of the evidence available establishes a definite pattern of knowing, willful or negligent noncompliance with the emergency medical examination, treatment or transfer requirements of §489.24.]

If we receive a complaint to the effect that a Medicare hospital willfully and knowingly, or negligently, did not comply with the emergency medical screening, stabilizing treatment or transfer requirements, we would consider the complaint a substantial allegation. If there is a substantial allegation, we would investigate the allegation thoroughly. Upon receipt of all the available information and evidence, we would determine whether there is knowing, willful or negligent noncompliance with our regulations.

We would determine that the hospital knowingly, willfully, or negligently failed to comply with the requirements of §489.24 based on such factors as the number of violations substantiated, the period of time during which the violations occurred, the seriousness of the individuals' conditions seeking emergency medical care, evidence of treatment being not provided or inadequate, evidence of patients in unstable condition not being properly transferred as defined in §489.24(d)(2), evidence of the hospital's actions or lack of actions causing a patient's death or serious or permanent impairment to a patient's bodily functions, or evidence of a hospital's actions placing a patient's health in serious jeopardy. We would determine the hospital negligent if the hospital and its personnel failed to exercise care that should normally be supplied to a patient experiencing an emergency medical condition as defined in §489.24(b). A hospital's failure to comply would also require us to determine whether to impose the sanctions of §489.24(e); that is, whether to suspend or terminate the provider agreement. Our determination to enforce the sanctions would depend on the judgment of the Secretary regarding the preponderance of the evidence available.

If we determine that a hospital should be suspended, we would give notice to the hospital with the suspension becoming effective five days after the date of the notice. The hospital would be able to appeal the suspension before an administrative law judge of the Office of Hearings and Appeals of the Social Security Administration. The suspension would be for a minimum of 30 days. We would pay for any covered services furnished to Medicare beneficiaries admitted before the suspension was effective, up to a maximum of 30 days.

We would revise 42 CFR 489.53, Termination by HCFA, to include failure to comply with the requirements of §489.24 as a cause for termination. We would add a new section, §489.56, Suspension of provider by HCFA, to show that HCFA may suspend rather than terminate a provider failing to meet the requirements of §489.24.

We invite public comment on any additional criteria we should adopt concerning the initiation of the complaint or enforcement procedures.

b. Civil Monetary Penalties

1. General

- In addition to termination or suspension of the provider agreement, if a hospital knowingly [and willfully, or negligently,] not in statute violates the requirements concerning screening, treatment and transfer, HHS could also impose a civil money penalty of not more than $25,000 for each violation.
- HHS could also impose a civil money penalty upon the "responsible physician" of not more than $25,000 for each violation. A responsible physician is a physician within the meaning of section 1861(r)(1) of the Act (doctor of medicine or osteopathy) who is employed by, or under contract with the hospital, who, in that capacity, had professional responsibility for the provision of examination or treatment for the individual, or transfer of the individual, when the violation occurred. A physician may be employed by, or under contract

with, a hospital even though the physician receives no compensation from the hospital for furnishing medical services.

For purposes of this provision, a physician would be considered under contract with the participating hospital, and therefore a responsible physician within the context of these regulations, if he or she has a written or oral agreement to take professional responsibility for providing examinations or treatment in the hospital's emergency room for individuals seeking emergency medical care, or for the proper transfer of these individuals, whether or not the physician receives compensation from the hospital for providing the services.

In addition, if the provision of emergency medical services is shared by more than one responsible physician, each responsible physician could be held liable and a civil money penalty could be imposed either against a single responsible physician or jointly against all or some of the responsible physicians. However, the total penalty amount per violation could not exceed $25,000 per violation.

"Other qualified medical personnel when a physician is not readily available in the emergency department" would not be "responsible physicians" for purposes of these regulations. The employer of the personnel - hospital, physician or physician group - would be responsible for any violations by these personnel.

We would revise §§1003.100, 1003.102 and 1003.103 to reflect these provisions.

2. Determination of penalty amount

We propose to establish in 42 CFR 1003.106 four criteria that we would consider in determining the penalty amount--

- The degree of culpability of the hospital and the responsible physicians.
- The seriousness of the individual's condition in seeking emergency medical services.

- The prior history of the hospital and the responsible physicians in failing to provide appropriate emergency medical services or appropriate transfers.
- Other matters required by justice.

We specifically welcome comment on the application of these and other possible criteria, and on the inclusion of specific aggravating and mitigating factors, to be considered in levying penalties under this provision.

We believe that the authority to assess civil money penalties against the responsible physician as well as the hospital will be a strong incentive for both the physician and the hospital to respond to the medical needs of individuals with emergency medical conditions and women in active labor.

We would refer cases for possible money penalties to the Department's Office of Inspector General (OIG). The method for making referrals to the OIG would be as follows:

When HCFA establishes a pattern of noncompliance with any of the provisions of section 9121, it would refer the case to the OIG Field Office (OIG/FO). With a particularly flagrant violation, resulting in extremely serious consequences, HCFA would notify the OIG/FO by telephone as soon as possible, in order to discuss the violation and to determine if a referral is appropriate even without a pattern being established. In both instances, a written transmittal to the OIG would be required, together with any documentation which establishes a pattern of noncompliance or a flagrant violation. The referral would contain a summary of the investigation to date, thus enabling the OIG/FO to determine whether to seek civil monetary penalties.

The Inspector General would have to prove by a preponderance of the evidence that the hospital or the responsible physician, or both, failed to provide emergency medical care as required by section 1867 of the Act. This provision would be in 42 CFR 1003.114.

The OIG would notify hospitals and responsible physicians assessed civil money penalties in accordance with 42 CFR 1003.109. We would revise that section to require that the notice would include a description of the episode for which the penalty is proposed and why the penalty is being assessed.

We would also make necessary technical changes to §§1003.100, 1003.105, 1003.106, 1003.109 and 1003.114 and add to §1003.101 definitions of "participating hospital" and "responsible physician", as discussed above.

b. Civil enforcement

An individual who suffers personal harm, or a medical facility that suffers a financial loss, as a direct result of the hospital's violation of a requirement in 42 CFR 489.24, may bring a civil action, in an appropriate Federal district court, against the hospital for damages and other equitable relief as appropriate. No civil action may be brought more than two years after the date of the violation. The Federal district court will apply the law of the State in which the hospital is located. According to the Conference Committee Report, the committee included the language concerning other equitable relief as appropriate as a directive to the courts:

> "[t]he [House of Representatives] language allowing courts to grant 'other appropriate relief' was also modified to read 'other equitable relief as appropriate', to give the courts clearer direction that such relief should be within the courts regular equitable powers and should be granted for the purpose of remedying the violation or deterring subsequent violations." (H.R. Rep. No. 453, 99th Cong., 1st Sess. 476 (1985).)

We do not believe it necessary or appropriate to revise the regulations to reflect this provision.

d. Preemption of State law

The legislation provides that it does not preempt State or local law except where there is a conflict with the statutory provision. Since Federal law ordinarily supersedes State law where there is a conflict, it is not necessary to include this provision in regulations.

Regulatory Impact Statement

a. Introduction

Executive Order (E.O.) 12291 requires us to prepare and publish an initial regulatory impact analysis for any proposed regulation that meets one of the E.O. criteria for a "major rule"; that is, that would be likely to result in: an annual effect on the economy of $100 million or more; a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or, significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets. In addition, we generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless the Secretary certifies that a proposed regulation would not have significant economic impact on a substantial number of small entities. For purposes of the RFA, we treat all providers as small entities.

b. Impact on CHAMPUS, CHAMPVA, and VA programs

This proposed rule would require hospitals to provide inpatient hospital services to individuals who have insurance coverage under CHAMPUS, CHAMPVA, and VA programs.

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Further, payment from these programs must be accepted as payment in full. The effect of these two requirements is the result of the statute, not this proposed rule.

c. Impact on hospitals

The provision requiring Medicare participating hospitals to provide emergency services to any individual with an emergency medical condition and to any woman in active labor would ensure that everyone in an emergency situation will be stabilized before discharge or transfer, or the hospital may be terminated. This provision is also the result of the statute and not this proposed rule. Further, it should be noted that currently under 42 CFR 124.600, et. seq., of the Public Health Service (PHS) regulations nearly 5 thousand hospitals nationwide, which received Hill Burton construction grants and loans, are required to participate in the Medicare program if eligible to do so. Under these regulation hospitals are required to provide emergency medical services to any person who resides (or, in the case of some hospitals, works) in the hospital's designated health service area. We believe the great majority of these hospitals comply with the earlier requirements. As a result, the economic impact of this proposed rule should be minimal, primarily affecting only those hospitals not already under such an agreement, those not complying with their agreements, or those hospitals that as a matter of policy have interpreted their obligations narrowly and refused services to individuals not specifically covered by the Hill Burton requirements.

d. Impact on patients

After the 1979 establishment of the above-mentioned Hill-Burton requirement very few community service complaints had been filed with PHS' Office for Civil Rights, although numerous criticisms have been reported in the media concerning admissions for emergency services. We believe that establishment of an additional, broader requirement and an additional avenue of complaint may result in reporting of a larger number of incidents. However, in view of the PHS experience we anticipate those incidents to be sporadic and relatively isolated. We expect this provision to increase the incentives for hospitals to avoid such incidents, which will minimize future negative perceptions and at the same time improve health services for all patients.

e. Conclusion

For these reasons, we have determined that a regulatory impact analysis is not required. Further, we have determined, and the Secretary certifies, that this proposed rule will not have a significant economic impact on a substantial number of small entities, and we have therefore not prepared a regulatory flexibility analysis.

Paperwork Reduction Act

These changes would not impose paperwork collection requirements. Consequently, they need not be reviewed by the Executive Office of Management and Budget under the authority of the Paperwork Reduction Act of 1980 (44 U.S.C. 3801 et. seq.).

Response to Comments

Because of the large number of comments we receive on proposed regulations, we cannot acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments received timely and respond to the major issues in the preamble to that rule.

List of Subjects

42 CFR Part 485

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare.

42 CFR Part 1003

Administrative practice and procedures, Archives and records, Grant programs-social programs, Maternal and child health, Medicaid, Medicare, Penalties.

Title 42 of the Code of Federal Regulations would be amended as follows:

A. Chapter IV, Part 489 is amended as follows:

PART 489 - PROVIDER AGREEMENTS UNDER MEDICARE

1. The authority citation for Part 489 is revised to read as follows:

AUTHORITY: Secs. 1102, 1861, 1864, 1866, 1867, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x, 1395aa, 1395cc, 1395dd and 1395hh), and sec. 602(k) of Pub. L. 98-21 (42 U.S.C. 1395ww note).

2. The table of contents is amended by adding §§489.24, 489.25, 489.26, and 489.27 to Subpart B, revising the heading for Subpart E, and adding 489.56 to read as follows:

PART 489 - PROVIDER AGREEMENTS UNDER MEDICARE

* * * * *

Subpart B - Essentials of Provider Agreements

* * * * *

489.24 Special responsibilities of Medicare hospitals in emergency cases.

489.25 Special requirements concerning the CHAMPUS and CHAMPVA programs.

489.26 Special requirements concerning veterans.

489.27 Beneficiary statement of discharge rights.

* * * * *

~~Subpart E—Termination of Agreement and Reinstatement after Termination~~

Subpart E--Termination or Suspension of Agreement: Reinstatement after Termination

* * * * *

489.56 Suspension of provider by HCFA.

* * * * *

3. Section 489.20 is revised by adding paragraphs (f), (g), (h), and (i), and by revising paragraphs (d) and (e) as follows:

489.20 Basic commitments.

The provider agrees--

* * * * *

(d) In the case of a hospital that furnishes inpatient hospital services to a beneficiary, to either furnish directly or make arrangements for all items and services (other than physicians' services as described in § 405.550(b) of this chapter) for which the beneficiary is entitled to have payment made under Medicare; ~~and~~

(e) In the case of a hospital that furnishes inpatient hospital services for which payment may be made under Subpart D of Part 405 of this chapter, to maintain an agreement with a utilization and quality control peer review organization (if there is such an organization for the area in which the hospital is located, which has a contract with HCPA under Part B of title XI of the Act) for that organization to review the admissions, quality, appropriateness, and diagnostic information related to such inpatient hospital ~~services~~ services;

(f) In the case of a hospital with an emergency department, to comply with §489.24 of this subpart;

(g) In the case of inpatient hospital services, to participate in any health plan contracted for under 10 U.S.C. 1079 or 1086 or 38 U.S.C. 613, in accordance with §489.25 of this subpart;

(h) In the case of inpatient hospital services, to admit veterans whose admission has been authorized under 38 U.S.C. 603, in accordance with §489.26 of this subpart; and

(i) In the case of a hospital, to comply with §489.27 of this subpart by giving each beneficiary a statement of his or her discharge rights.

4. A new 489.24 is added to read as follows:

§489.24 Special responsibilities of Medicare hospitals in emergency cases

(a) General. In the case of a hospital that has an emergency department, if any individual (whether or not eligible for Medicare benefits) comes to the emergency department and a request is made on the individual's behalf for examination or treatment of a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition exists or to determine if the individual is in active labor. The examinations must be conducted by individuals qualified to conduct these examinations, based on training and experience obtained in hospital emergency departments.

(b) Definitions.

"Active labor" means labor at a time at which delivery is imminent; there is inadequate time to effect safe transfer to another hospital before delivery; or a transfer may pose a threat to the health and safety of the patient or the unborn child.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

(1) placing the patient's health in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

"Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from a facility.

"To stabilize" means, with respect to an emergency medical condition, to provide the medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

"Transfer" means the movement (including the discharge) of a patient to outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of a patient who (1) has been declared dead, or (2) leaves the facility without the permission of any such person.

(c) Necessary stabilizing treatment for emergency medical conditions and active labor.

(1) General. If any individual (whether or not eligible for Medicare benefits) comes to a

hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide either--

(A) Within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition or to provide for treatment of the labor; or

(B) For transfer of the individual to another medical facility in accordance with paragraph (d) of this section.

(2) Refusal to consent to treatment. A hospital meets the requirements of paragraph (c)(1)(A) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph but the individual (or a legally responsible person acting on the individual's behalf) refuses to consent to the examination or treatment.

(3) Refusal to consent to transfer. A hospital meets the requirements of paragraph (c)(1)(B) of this section with respect to an individual

if the hospital offers to transfer the individual to another medical facility in accordance with paragraph (d) of this section but the individual (or a legally responsible person acting on the individual's behalf) refuses to consent to the transfer.

(d) Restricting transfers until the patient is stabilized.

(1) General. If a patient at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section) or is in active labor, the hospital may not transfer the patient unless--

(A)(i) The patient (or a legally responsible person acting on the patient's behalf) requests the transfer; or

(ii) A physician (within the meaning of section 1861(r)(1) of the Act, or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from being transferred; and

(B) the transfer is an appropriate transfer.

(2) A transfer to another medical facility will be appropriate only in those cases--

(A) in which the receiving facility--

(i) has available space and qualified personnel for the treatment of the patient; and

(ii) has agreed to accept transfer of the patient and to provide appropriate medical treatment;

(B) in which the transferring hospital provides the receiving facility with appropriate medical records (or copies of them) of the examination and treatment furnished at the transferring hospital;

(C) in which the transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer; and

(D) that meets such other requirements as the Secretary may find necessary in the interest of the health and safety of patients transferred.

(e) Termination or suspension of provider agreement. If a hospital knowingly and willfully, or negligently, fails to meet the requirements of this section, HCFA may--

(1) Terminate the provider agreement under §489.53 of this subpart; or

(2) Suspend the provider agreement under §489.56 for a period of time it determines appropriate after reasonable notice to the public and the hospital.

5. A new §489.25 is added to read as follows:

§489.25 Special requirements concerning CHAMPUS and CHAMPVA programs.

For inpatient services, a hospital that participates in the Medicare program must participate in any health plan contracted under 10 U.S.C. 1079 or 1086 (Civilian Health and Medical Program of the Uniformed Services) and under 38 U.S.C. 613 (Civilian Health and Medical Program of the Veterans Administration) and accept the CHAMPUS/CHAMPVA-determined allowable amount as payment in full. Hospitals must meet the requirements of 33 CFR Part 199 concerning program benefits under the Department of Defense. This section applies to inpatient services furnished to beneficiaries admitted on or after January 1, 1987.

6. A new §489.26 is added to read as follows:

§489.26 Special requirements concerning veterans.

For inpatient services, a hospital that participates in the Medicare program must admit any veteran whose admission is authorized by the Veterans Administration under 38 U.S.C. 603 and must meet the requirements of 38 CFR Part 17 concerning admissions practices and payment methodology and amounts. This section applies to services furnished to veterans to admitted on and after July 1, 1987.

7. A new §489.27 is added to read as follows:

§489.27 Beneficiary statement of discharge rights.

A hospital that participates in the Medicare program must furnish each Medicare beneficiary, or an individual acting on his or her behalf, the statement of discharge rights HCFA supplies to the hospital to implement section 1866(a)(1)(M) of the Act. The hospital must furnish the statement at or about the time of admission. This provision is effective with admissions beginning on or after [60 days after HHS-prescribed notice is written].

8. The heading of Subpart E is revised to read as follows:

Subpart E—Termination of ~~Agreement and~~ **Reinstatement After Termination**
—or Suspension
Agreement;

9. In §489.53, the introductory language of paragraph (a) is republished and paragraph (a) is amended by adding subparagraphs (10), (11), and (12) to read as follows:

§ 489.53 Termination by HCFA.

(a) *Basis for termination of agreement with any provider.* HCFA may terminate the agreement with any provider if HCFA finds that any of the following failings is attributable to that provider:

* * * * *

(10) In the case of a hospital that has an emergency department, the hospital failed to comply with §489.24 of this part, which requires the hospital to examine, treat or transfer emergency medical cases appropriately. (HCFA may instead suspend the agreement; see §489.56 of this subpart.)

(11) In the case of a hospital requested to furnish inpatient services to CHAMPUS or CHAMPVA beneficiaries or to veterans, it failed to comply with §489.25 or §489.26 of this part, respectively.

(12) It failed to furnish the notice of discharge rights as required by §489.27 of this part.

10. A new §489.56 is added to read as follows:

§489.56 Suspension of provider by HCFA.

HCFA may suspend the agreement, for a period of time it determines appropriate, with any hospital with an emergency department that fails to meet the requirements of §489.24 of this part, concerning examination, treatment and transfer of emergency medical cases. If HCFA decides to suspend the agreement, rather than terminate the agreement (see §489.53(a)(10) of this subpart), HCFA will give the hospital and public reasonable notice.

B. Chapter V, Part 1003 is amended as follows:

Part 1003 - CIVIL MONEY PENALTIES
AND ASSESSMENTS

1. The authority citation for Part 1003 is revised to read as follows:

~~AUTHORITY: Secs. 1102, 1128, 1128A and 1842(j) of the Social Security Act (42 U.S.C. 1302, 1320a-7, 1320a-7a, and 1395u(j)).~~

AUTHORITY: Secs. 1102, 1128, 1128A, 1842(j) and 1867(d)(2) of the Social Security Act (42 U.S.C. 1302, 1320a-7, 1320a-7a, 1395u(j) and 1395dd(d)(2)).

2. Section 1003.100 is amended by revising paragraphs (a) and (b) to read as follows:

§ 1003.100 Basis and purpose.

(a) *Basis.* This part implements sections 1128(c), 1128A, ~~and~~ 1842(j), and 1867(d)(2) of the Social Security Act (42 U.S.C. 1320a-7(c), 1320a-7a, ~~and 1395u(j)).~~ 1395u(j), and 1395dd(d)(2)).

(b) *Purpose.* This part (1) establishes procedures for imposing (i) civil money penalties and assessments against persons who have submitted certain prohibited claims under the Medicare, Medicaid, or the Maternal and Child Health Services Block Grant programs, and (ii) civil money penalties against a participating hospital with an emergency department and responsible physician or physicians who fail to provide emergency medical care as specified in §489.24 of this title;

(2) establishes procedures for suspending from the Medicare and Medicaid programs, persons against whom a civil money penalty or assessment has been imposed; and (3) specifies the appeal rights of persons subject to a penalty or assessment.

C. Section 1003.101 is amended by adding definitions for the terms "participating hospital" and "responsible physician" to read as follows:

1003.101 Definitions.

For purposes of this part:

* * * * *

Participating hospital means a hospital that has entered into a Medicare provider agreement under section 1866 of the Act and has, under the agreement, obligated itself to comply with the requirements of section 1867 of the Act.

* * * * *

Responsible physician means a physician within the meaning of section 1861(r)(1) of the Act who (i) is employed by, or is under contract with, the participating hospital in providing medical services, and (ii) acting in such capacity, has professional responsibility for the provision of examinations or treatments for an individual, or transfer of the individual, who is seeking emergency medical care or who is in active labor.

* * * * *

4. Section 1003.102 is amended by redesignating existing paragraph (c) as paragraph (d), and by adding a new paragraph (c) and a new subparagraph (d)(3) to read as follows:

§1003.102 Basis for civil money penalties and assessments.

* * * * *

(c) The OIG may impose a penalty against a participating hospital with an emergency department, any responsible physician, or both, that it determines in accordance with this part has knowingly, willfully or negligently violated section 1867(a)-(c) of the Act (42 U.S.C. 1395dd(a),(b) and (c)). (See §489.24 of this title.)

(d) ~~(e)~~(1) In any case in which it is determined that more than one person was responsible for presenting or causing to be presented a claim as described in paragraph (a) of this section, each such person may be held liable for the penalty prescribed by this part, and an assessment may be imposed against any one such person or jointly and severally against two or more such persons, but the aggregate amount of the assessments collected may not exceed the amount that could be assessed if only one person was responsible.

(2) In any case in which it is determined that more than one person was responsible for presenting or causing to be presented a request for payment described in paragraph (b) of this section, each such person may be held liable for the penalty prescribed by this part.

(3) In any case in which it is determined that more than one physician was responsible for knowingly, willfully or negligently failing to provide care to an individual who is seeking emergency medical treatment or who is in active labor in accordance with section 1867 of the Act, a penalty may be imposed against any one responsible physician, or jointly and severally against two or more physicians, deemed responsible for failing to provide the required care. The aggregate amount of the penalty levied, however, may not exceed the amount that could be assessed if only one physician were deemed responsible.

5. Section 1003.103 is revised by designating the existing content as paragraph (a), revising paragraph (a) and adding a new paragraph (b) to read as follows:

(a) **§ 1003.103 Amount of penalty.**

The OIG may impose a penalty of not more than $2,000 for each item of service that is subject to a determination under ~~§ 1003.102.~~ §1003.102(a) and (b) of this subpart.

(b) The OIG may impose a penalty of not more than $25,000 against a participating hospital and a penalty of not more than $25,000 against the responsible physician or physicians for each violation subject to a determination under §1003.102 (c) and (d)(3).

6. Section 1003.105 is amended by revising paragraph (a) to read as follows:

§ 1003.105 Suspension from participation in Medicare or Medicaid.

(a) A person subject to a penalty or assessment determined under § 1003.102 (a) and (b) may, in addition, be suspended from participation in Medicare for a period of time determined under § 1003.107. The OIG may require the appropriate State agency to suspend the person from the Medicare program for a period he shall specify. The State agency may request the Secretary to waive suspension of a person from the Medicaid program under this section if it concludes that, because of the shortage of providers or other health care personnel in the area, individuals eligible to receive Medicaid benefits would be denied access to medical care or that such individuals would suffer hardship. The ~~Secretary~~ OIG will notify the State agency if and when the ~~Secretary~~ it waives suspension in response to such a request.

* * * * *

7. Section 1003.106 is amended by designating the introductory language of (b) as (b)(1) and redesignating current subparagraphs (b)(1)-(5) as (b)(1)(i)-(b)(1)(v) and by revising paragraphs (a), redesignated (b)(1)(iii) and (c) to read as follows:

§ 1003.106 Determinations regarding the amount of the penalty and assessment.

(a) (1) In determining the amount of any penalty or ~~assessment, the Department shall take into account, in accordance with this section.~~

in accordance with §1003.102(a) and (b), the OIG will take into account:

(i) The nature of the claim or request for payment and the circumstances under which it was presented,

(ii) The degree of culpability of the person submitting the claim or request for payment,

(iii) The history of prior offenses of the person submitting the claim ~~or request~~ request for payment,

(iv) The financial condition of the person presenting the claim or request for payment, and

(v) Such other matters as justice may require.

(2) In determining the amount of any penalty in accordance with §1003.102(c), the OIG will take into account:

(i) the degree of culpability of the participating hospital and the responsible physician or physicians;

(ii) the seriousness of the condition of the individual seeking emergency medical treatment;

(iii) the prior history of offenses of the hospital and responsible physician or physicians in their failure to provide appropriate emergency medical screening, stabilization and treatment of the patient, or to effect an appropriate transfer of the patient to another facility; and

(iv) such other matters as justice may require.

(b) *Guidelines for determining the amount of the penalty or assessment.* (1) As guidelines for taking into account the factors listed in paragraph ~~(a)~~ (a)(1) of this section, the following circumstances are to be considered:

(i) ~~(1)~~ *Nature and circumstances of the claim.* It should be considered a mitigating circumstance if all the items or services subject to a determination under § 1003.102 included in the action brought under this part were of the same type and occurred within a short period of time, there were few such items or services, and the total amount claimed for such items or services was less than $1,000. It should be considered an aggravating circumstance if such items or services were of several types, occurred over a lengthy period of time, there were many such items or services (or the nature and circumstances indicate a pattern of claims for such items or services), or the amount claimed for such items or services was substantial.

(ii) ~~(2)~~ *Degree of culpability.* It should be considered a mitigating circumstance if the claim for the item or service was the result of an unintentional and unrecognized error in the process respondent followed in presenting claims, and corrective steps were taken promptly after the error was discovered. It should be considered an aggravating circumstance if the respondent knew the item or service was not provided as claimed, or if the respondent knew that no payment could be made because he had been excluded from program reimbursement as specified in § 1003.102(a)(2) or because payment would violate the terms of an assignment agreement or an agreement with a State agency under § 1003.102(b).

(iii) ~~(3)~~ *Prior offenses.* It should be considered an aggravating circumstance if at any time prior to the presentation of any claim which included an item or service subject to a determination under ~~§ 1003.106~~ §1003.102 (a) and (b), the respondent was held liable for criminal, civil, or administrative sanctions in connection with a program covered by this part or any other public or private program of reimbursement for medical services.

(iv) ~~(4)~~ *Financial condition.* It should be considered a mitigating circumstance if imposition of the penalty or assessment without reduction will jeopardize the ability of the respondent to continue as a health care provider. In all cases, the resources available to the respondent will be considered when determining the amount of the penalty and assessment.

(v) ~~(5)~~ *Other matters as justice may require.* Other circumstances of an aggravating or mitigating nature should be taken into account if, in the interests of justice, they require either a reduction of the penalty or assessment or an increase in order to assure the achievement of the purposes of this part.

(c) As guidelines for determining the amount of the penalty and assesament to be imposed, for every ~~item or service~~ item, service or incident subject to a determination under ~~§ 1003.102~~ §1003.102(a) and (b):

(1) If there are substantial or several mitigating circumstances, the aggregate amount of the penalty and assessment should be set at an amount sufficiently below the maximum permitted by §§ 1003.103(a) ~~and 1003.104~~, to reflect that fact.

(2) If there are substantial or several aggravating circumstances, the aggregate amount of the penalty and assessment should be set at an amount sufficiently close to or at the maximum permitted by §§ 1003.103(a) ~~and 1003.104~~, to reflect that fact.

(3) Unless there are extraordinary mitigating circumstances, the aggregate amount of the penalty and assessment should never be less than double the approximate amount of damages sustained by the United States, or any State, as a result of claims subject to a determination under ~~§ 1003.102~~ §1003.102(a) and (b).

* * * * *

8. Section 1003.109 is amended by revising paragraph (a) to read as follows:

§ 1003.109 Notice of proposed determination.

(a) If the Inspector General proposes to impose a penalty and assessment, or to suspend a respondent from participation in Medicare or Medicaid, in accordance with this part, he or she must deliver or send by certified mail, return receipt requested, to the respondent, written notice of his or her intent to impose a penalty, assessment and suspension, as applicable. The notice will include reference to the statutory basis for the penalty, assessment, and suspension; description of the claims and requests for payment with respect to which the penalty, assessment, and suspension are proposed (except in cases where the Inspector General is relying upon statistical sampling pursuant to ~~§ 1003.112,~~ in which case the notice shall describe those claims and requests for payment comprising the sample upon which the Inspector General is relying and shall also briefly describe the statistical sampling technique utilized by the Inspector General);

(1)

(2) with respect to determinations under §1003.102(a) and (b), a

§1003.133

(3) with respect to determinations under §1003.102(c), a description of the episode with respect to which the penalty is proposed; (4) the reason why such claims and requests for payment, or failure to provide emergency medical services as required under section 1867 of the Act, subject

~~the reason why such claims and requests for payment subject~~ the respondent to a penalty, assessment, and suspension; the amount of the proposed penalty, assessment, and the period of proposed suspension (where applicable); (5) any circumstances described in § 1003.106 which were considered when determining the amount of the proposed penalty and assessment and the period of suspension; (6) instructions for responding to the notice, including a specific statement of respondent's right to a hearing, of the fact that failure to request a hearing within 30 days permits the imposition of the proposed penalty, assessment, and suspension without right to appeal, and of respondent's right to request an extension of time in which to respond to the notice and a copy of the rules contained in this part.

* * * * *

9. Section 1003.114 is amended by revising paragraphs (a) and (b), by revising and redesignating existing paragraphs (c) and (d) as paragraphs (d) and (e), respectively, and by adding a new paragraph (c) to read as follows:

§ 1003.114 Issues and burden of proof.

(a) To the extent that a proposed penalty and assessment is based on claims or requests for payment presented on or after August 13, 1981, the Inspector General must prove by a preponderance of the evidence that the respondent presented or caused to be presented such claims or requests for payment as described in ~~§ 1003.102.~~

§1003.102(a) and (b)

(b) To the extent that a proposed penalty and assessment is based on claims presented before August 13, 1981, the Inspector General must prove by clear and convincing evidence that:

(1) The respondent presented or caused to be presented such claims as described in ~~§ 1003.102;~~ and

§1003.102(a) and (b);

(2) Presenting or causing to be presented such claims could have rendered respondent liable under the provisions of the False Claims Act, 31 U.S.C. 3729 *et seq.*, for payment of an amount not less than that proposed.

(c) To the extent that a proposed penalty is based on violation of section 1867 of the Act, the Inspect General must prove by a preponderance of the evidence that the hospital and responsible physician or physicians failed to provide emergen medical care as described in §1003.102(c).

(d) ~~(c)~~ Where a final determination that the respondent (1) ~~presented or caused to be presented a claim or request for payment falling within the scope of §1003.102~~

§1003.102(a) or (b), or (2) failed to provide emergency medical services within the scope of §1003.102(c),

has been rendered in any proceeding in which the respondent was a party and had an opportunity to be heard, the respondent shall be bound by such determination in any proceeding under this part.

(e) ~~(d)~~ The respondent shall bear the burden of producing and proving by a preponderance of the evidence any circumstances described in § 1003.106 that would justify reducing the amount of the penalty or assessment, or the period of suspension.

Dr. Kellermann subsequently submitted the following information:

THE MED

July 2, 1987

Mr. Frank Almendarez
Dept. of Health & Human Services
Office of Inspector General
Office of Analysis & Inspections
Regional VI
1100 Commerce Street, Room 4E6
Dallas, TX 75242

Dear Mr. Almendarez:

Enclosed are copies of supporting material relevant to your review of emergency department patient "dumping" in Tennessee. They include:

A) SB1410, Tennessee General Assembly.
B) Tennessee Hospital Association (THA) reaction to COBRA and to SB1410.
C) Original proposed transfer regulations of State of Tennessee (rejected).
D) Current proposed transfer regulations for Tennessee (under fire by THA).
E) Proposed transfer policy for the Regional Medical Center at Memphis emphasising patient consent prior to transfer and physician certification of "stability" prior to transfer, in addition to cobra provisions.
F) An analysis of COBRA by NAPH.
G) Our current Med ER admission and transfer policy.
H) Ambulance transfer datasheet - The MED.
I) Abstract: Patient "dumping" in the Mid-South.
J) Severity of illness criteria used in I) above.
K) Tables relevant to I) above.
L) Illustrative "problem transfer" cases.
    a) S.P. 1/86 +
    b) C.P. 11/9/86 **
        L.B. 11/12/86 **
        M.C. 11/17/86 +
    c) M.R. 3/87 +
    d) J.A. 5/87 +
    e) J.R. 6/87 *

* died prior to transfer
** died following transfer
+ emergency surgery and/or ICU admission

REGIONAL MEDICAL CENTER AT MEMPHIS
877 Jefferson Avenue, Memphis, Tennessee 38103
A Shelby County Government Service

Call writer direct

I hope this material may be of use to you and the Office of Inspector General, DHHS.

Sincerely,

Arthur Kellerman

Arthur Kellermann, M.D., M.P.H.
Assistant Professor and Chief
Division of Emergency Medicine
Department of Medicine
University of Tennessee, Memphis

Medical Director
Emergency Services
Regional Medical Center at Memphis

AK:ms

Enclosure(s)

cc: Gary Shorb, President

PUBLIC CHAPTER NO. 711

SENATE BILL NO. 1410

By Ford

Substituted for: House Bill No. 1725

By DeBerry, Dixon

AN ACT Relative to the transfer of patients from one hospital to another and to amend Tennessee Code Annotated, Title 68, Chapt

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE.

SECTION 1. Tennessee Code Annotated, Title 68, Chapter 11, is mended by adding Sections 2 through 5 of this act as new, ppropriately numbered sections.

SECTION 2. It is the intent of the General Assembly that the Tennessee Department of Health and Environment, acting through the Board for Licensing Health Care Facilities created at Tennessee Code nnotated, Section 68-11-203, shall promulgate rules, in accordance with the provisions of the Tennessee Code Annotated, Title 4, Chapter , to regulate the transfer of inpatients between hospitals and that npatients should not henceforth be involuntarily transferred for urely economic reasons but should receive the needed medical care as equired by Tennessee Code Annotated, Title 68, Chapter 39, Part 3. 68-11-701

SECTION 3. (a) The Tennessee Department of Health and Environment, cting through the Board for Licensing Health Care Facilities created t Tennessee Code Annotated, Section 68-11-203, shall adopt rules, in ccordance with the provisions of Tennessee Code Annotated, Title 4, hapter 5, to provide standards governing the transfer of hospital npatients. The rules shall provide that inpatient transfers between ospitals shall be accomplished in a medically reasonable manner by roviding for: 68-11-702

(1) the transfer of patients requiring emergency services who have sustained an injury or who are suffering from an acute medical condition where the same is liable to cause death, severe injury, or severe illness, as determined by a physician, only after having complied with the requirements of Tennessee Code Annotated, Title 68, Chapter 39, Part 3;

(2) the use of medically reasonable life support measures to stabilize the patient prior to transfer and to sustain the patient during the transfer as determined by a physician;

Reference Law Manual Section No. VII

COMMENT: This act requires the Health Care Licensing Board to promulgate regulations dealing with the issue of patient transfers between hospital facilities in Tennessee. It states a legislative intent that involuntary transfers should be only for medical reasons and not for purely economic considerations. The Licensing Board is directed to promulgate regulations to effectuate this intent.

Section 3 of the bill contains a listing of items which, at a minimum, must be included in or addressed by the regulations.

At the time of publication of this supplement, the Licensing Board is engaged in studying the patient transfer issue with a eye toward promulgation of regulations to take effect on or shortly after the first of the year. When such regulations are issued in final form, all member institutions of THA will be advised of their content and any action necessary by the institution to comply with the regulation's requirements.

TENNESSEE HOSPITAL ASSOCIATION
500 Interstate Blvd. South • Nashville, Tennessee 37210 • 615/256-8240

JUN 16 1986

MEMORANDUM

TO: Chief Executive Officers of Member Institutions

FROM: Charlie Cato, Corporate Counsel

DATE: June 12, 1986

SUBJ: Medicare Amendments Related to Transfers of Emergency Room Patients

Attached to this memo is a copy of recent federal amendments to the Medicare Act dealing with hospital procedures for transfer of emergency room patients. These provisions take effect on August 1, 1986 and constitute a substantial amendment to the Medicare law which should force a thorough re-examination of your emergency room treatment procedures and policies.

Although the language of the statute makes for relatively easy reading, as acts of Congress go, I have summarized in this memo some of the more significant points of the new provisions. After examining both the summary and the language of the law itself, I strongly urge all of you to consult immediately with the appropriate staff members to begin a thorough examination of your emergency room procedures. Penalties for failure to comply with the new provisions are severe, and relatively simple procedural changes may be sufficient to comply with the letter of the law as written.

SUMMARY OF TRANSFER PROVISIONS

The thrust of the new provisions is to create a federal tort against any hospital provider who fails to "stabilize" patients who seek emergency room care. All hospitals operating emergency rooms become liable to a patient with an emergency medical condition or who is in active labor in the event the patient is transferred before stabilization of his condition. Be advised, that the provisions apply to all persons who present themselves at the emergency room seeking treatment, whether or not they are eligible for Medicare benefits.

When a patient presents himself at the emergency room requesting treatment, the hospital is obligated to provide "an appropriate medical screening examination" to the extent of the "capability of the hospital's emergency department". The exam is for the purpose of determining whether an emergency condition exists or whether the patient is in active labor. The act defines the term "emergency medical condition" as a condition in which the patient manifests acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious disfunction of any bodily organ or part. The term "active labor" is defined as a circumstance where (1) delivery is imminent; (2) there is inadequate time for a safe transfer prior to delivery; or (3) a transfer may pose a threat to the health and safety to the patient or the unborn child.

If a patient is determined to have either an emergency medical condition or to be in active labor, the hospital is obligated to provide whatever medical treatment is necessary to stabilize the patient. Sufficient medical care should be provided "to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from the transfer". Once the patient is stabilized, a transfer can be effectuated to another hospital, provided an appropriate facility is available and willing to accept the transfer.

Under certain circumstances, the act would not require treatment of patients with emergency medical conditions. These circumstances include situations where: (1) the patient refuses to consent to treatment or examination; (2) the patient refuses to consent to an appropriate transfer; (3) the patient requests a transfer to another hospital; or (4) the physician certifies "based on the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer."

PENALTIES FOR VIOLATION OF THE ACT

As mentioned earlier, penalties for violation of the act are varied and severe. A patient who can establish that he was harmed by the failure of the hospital to stabilize his emergency medical condition prior to transfer can bring an action in federal court against the hospital seeking damages for such harm. In addition, a hospital to whom a patient is transferred inappropriately, i.e. before proper stabilization, may also seek damages against the transferring hospital for any financial loss or increased cost which the inappropriate transfer occasioned. Both of these causes of action have a two year statute of limitations. More significantly, the Department of Health and Human Services can seek monetary penalties against either the hospital or the physician responsible for an inappropriate transfer. The penalties can range up to $25,000 per violation. Even worse, the act provides that failure to comply with the provisions may subject the hospital to suspension or termination of its Medicare provider contract.

PRACTICAL IMPACT OF THE EMERGENCY ROOM TRANSFER PROVISIONS

For the first time, the hospital is obligated under federal Medicare law to provide an appropriate examination to any patient presenting himself at the emergency room for treatment. If the examination determines that an emergency medical condition exists, under the definitions contained in the act, the hospital is required to treat the patient at least to the point of stabilizing his condition prior to transfer. If the physician is willing to certify that a transfer is in the medical best interest of the patient, then the stabilization treatment requirement may be waived. Of course, if a neighboring facility is vastly more equipped to treat a particular condition, informing the patient of this fact may encourage him to voluntarily request a transfer, thus relieving [illegible] the original facility of the requirement to stabilize prior to the transfer. Also note, that any transfer effectuated must be to an appropriate facility. An appropriate facility is considered to be one which has the resources to treat the patient and which has agreed to accept the transfer.

Once again, I cannot overemphasize the importance of examining immediately all emergency room procedure relevant to this issue to satisfy yourself that you comply with the act's provisions and that your personnel are informed of their obligations under the statute. Also, you should strongly consider examining your emergency room documentation to see to it that some written record exists to document your personnel's actions on each case. Your emergency room records should certainly contain a written report on any patient with an emergency medical condition which is transferred to another facility prior to stabilization. Such record must indicate that one of the permitted circumstances for such a transfer exists in the particular case. Also, some documentation regarding the appropriateness of the transferee facility should be included in the record. Finally, I urge that you share this information immediately with your institution's legal counsel for his review and recommendation regarding appropriate revisions to your procedures.

Finally, you may recall that in the 1986 session of the Tennessee legislature, a bill regulating patient transfers was introduced and ultimately passed after significant amendment. As amended, the legislation merely requires the Health Care Licensing Board to promulgate regulations dealing with the issue of patient transfers between hospitals. Significantly, we were able to amend the bill to provide that such regulations deal only with transfers of inpatients, thus excluding consideration of emergency room cases where no inpatient relationship has been established. The Licensing Board staff is only now beginning to consider the issue of drafting such regulations, and we hope to work closely with the staff and members of the Licensing Board as they address this issue during the summer and fall. Although we cannot speak to the final form which the regulations will take, we hope that they will turn out to be far less burdensome than the federal act summarized above. We will advise you as the drafting of the state regulations proceeds during the next several months.

msc
Attachment

"EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN ACTIVE LABOR

"Sec. 1867. (a) Medical Screening Requirement.—In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists or to determine if the individual is in active labor (within the meaning of subsection (e)(2)).

"(b) Necessary Stabilizing Treatment for Emergency Medical Conditions and Active Labor.—

"(1) In general.—If any individual (whether or not eligible for benefits under this title) comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide either—

"(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor, or

"(B) for transfer of the individual to another medical facility in accordance with subsection (c).

"(2) Refusal to consent to treatment.—A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph but the individual (or a legally responsible person acting on the individual's behalf) refuses to consent to the examination or treatment.

"(3) Refusal to consent to transfer.—A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) but the individual (or a legally responsible person acting on the individual's behalf) refuses to consent to the transfer.

"(c) Restricting Transfers Until Patient Stabilized.—

"(1) Rule.—If a patient at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(4)(B)) or is in active labor, the hospital may not transfer the patient unless—

"(A)(i) the patient (or a legally responsible person acting on the patient's behalf) requests that the transfer be effected, or

"(ii) a physician (within the meaning of section 1861(r)(1)), or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer; and

"(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

"(2) APPROPRIATE TRANSFER.—An appropriate transfer to a medical facility is a transfer—

"(A) in which the receiving facility—

"(i) has available space and qualified personnel for the treatment of the patient, and

"(ii) has agreed to accept transfer of the patient and to provide appropriate medical treatment;

"(B) in which the transferring hospital provides the receiving facility with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital;

"(C) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

"(D) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of patients transferred.

"(d) ENFORCEMENT.—

"(1) AS REQUIREMENT OF MEDICARE PROVIDER AGREEMENT.—If a hospital knowingly and willfully, or negligently, fails to meet the requirements of this section, such hospital is subject to—

"(A) termination of its provider agreement under this title in accordance with section 1866(b), or

"(B) at the option of the Secretary, suspension of such agreement for such period of time as the Secretary determines to be appropriate, upon reasonable notice to the hospital and to the public.

"(2) CIVIL MONETARY PENALTIES.—In addition to the other grounds for imposition of a civil money penalty under section 1128A(a), a participating hospital that knowingly violates a requirement of this section and the responsible physician in the hospital with respect to such a violation are each subject, under that section, to a civil money penalty of not more than $25,000 for each such violation. As used in the previous sentence, the term 'responsible physician' means, with respect to a hospital's violation of a requirement of this section, a physician who—

"(A) is employed by, or under contract with, the participating hospital, and

"(B) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred.

"(3) CIVIL ENFORCEMENT.—

"(A) PERSONAL HARM.—Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

"(B) FINANCIAL LOSS TO OTHER MEDICAL FACILITY.—Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

"(C) LIMITATIONS ON ACTIONS.—No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

"(e) DEFINITIONS.—In this section:

"(1) The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

"(A) placing the patient's health in serious jeopardy,

"(B) serious impairment to bodily functions, or

"(C) serious dysfunction of any bodily organ or part.

"(2) The term 'active labor' means labor at a time at which—

"(A) delivery is imminent,

"(B) there is inadequate time to effect safe transfer to another hospital prior to delivery, or

"(C) a transfer may pose a threat of the health and safety of the patient or the unborn child.

"(3) The term 'participating hospital' means hospital that has entered into a provider agreement under section 1866 and has, under the agreement, obligated itself to comply with the requirements of this section.

"(4)(A) The term 'to stabilize' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

"(B) The term 'stabilized' means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from a facility.

"(5) The term 'transfer' means the movement (including the discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of a patient who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

"(f) PREEMPTION.—The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of the first month that begins at least 90 days after the date of the enactment of this Act.

(d) REPORT.—The Secretary of Health and Human Services shall, not later than 6 months after the effective date described in subsection (c), report to Congress on the methods to be used for monitoring and enforcing compliance with section 1867 of the Social Security Act.

Version #1

PROPOSED HOSPITAL TRANSFER REGULATIONS

.01. DEFINITIONS AND GENERAL PRINCIPLES

For the purpose of administering these provisions, the Tennessee Department of Health and Environment and the Tennessee Board for Licensing Health Care Facilities now interpret the following terms and declare the following principles:

a. "Hospital" means any facility within the meaning of either Tennessee Code Annotated, Section 68-11-201(10), or Rule 1200-8-1-.02. The phrase "between hospitals" refers to the transfer of an inpatient between two (2) "hospitals", however classified, and also refers to the transfer of an inpatient between a licensed "hospital" and any distinct part or unit of a hospital which is licensed or certified to provide a different level of care.

b. "Transfer" means the physical movement of an inpatient between two (2) separately-licensed or certified facilities, distinct parts, or units. However, the term "transfer" and the provisions of these rules exclude the commitment and movement of mentally-ill and mentally-retarded persons, whose transfers are governed by Tennessee Code Annotated, Title 33. The term "transfer" does not apply to the discharge or release of a patient who is no longer in medical need of inpatient hospital care, nor to a hospital's lawful refusal, after an appropriate medical screening, to render any medical care upon the ground that the person does not have a medical need for the hospital level of care.

c. Although voluntary transfers are preferred, the transfer is "involuntary" whenever:

   (1) The person does not concur with, or consent to, the movement; or

   (2) The person's physical or mental condition precludes consent and no legally-authorized party consents in behalf of the person; or

   (3) The person, or the party consenting in their behalf, was given inadequate, incomplete, or misleading information about any of the following:

      (i) the medical necessity for the movement.

      (ii) the availability of appropriate medical services at the facility initiating the transfer.

      (iii) the availability of appropriate medical services at the receiving facility.

      (iv) the availability at both the facility initiating the transfer and at the receiving facility of indigent care and the facilities' legal obligations, if any, to provide medical services without regard to the patient's ability to pay.

(v) the person's eligibility for medical assistance programs of the federal, state or local government and, at both the facility initiating the transfer and at the receiving facility, the facilities' participation in such programs and, if participating, any obligation to accept the medical assistance program's reimbursement as payment in full for the needed medical care.

An involuntary transfer may be made only for medical reasons. An involuntary transfer may not be made for purely economic reasons.

d. "Inpatient" means any person who is either:

(1) suffering from an acute or chronic illness or injury; or

(2) crippled, convalescent or infirm; or

(3) in need of obstetrical, surgical, medical, nursing or supervisory care;

and who is received by a hospital under circumstances reasonably presenting the prospect that they may need care for a continuous period longer than twenty-four (24) hours (or for any period of time when maternity care involving labor and delivery) for the purpose of giving advice, diagnosis, nursing service, or treatment bearing on the physical health of such person.

e. "Medical emergency" means unstable, life-threatening conditions or acute trauma in which the life, limb, or body function of the patient depends upon the immediacy of medical treatment, particularly in conditions which will cause or will immediately lead to the cessation of breathing and/or cardiac function or loss of 20 percent or more of the victim's blood; or a person's perceived need for medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury.

f. "Emergency services" are the services utilized in response to the perceived need for medical care in order to prevent loss of life or aggravation of illness or injury. As used in these rules, emergency services also mean those services that:

(i) Prevent death, serious permanent disfigurement or loss or impairment of the function of a bodily member or organ; or

(ii) Provide for the care of a woman in active labor.

.02. STEPS IN AN APPROPRIATE TRANSFER

Before any transfer, whether of a patient who has been admitted or of a person who is received at the emergency room, whether voluntary or involuntary, the hospital must take the following steps:

a. Screening the Patient

Any patient who arrives at the emergency department of a hospital must be provided an appropriate medical screening examination to determine whether or not a medical emergency exists or a woman is in active labor. If a medical emergency exists, then appropriate emergency services shall be initiated.

b. Stabilizing the Patient

The patient must be adequately evaluated and treatment initiated to assure that transfer of a patient will not, within reasonable medical probability, result in death or loss or serious impairment of bodily functions, parts or organs.

Evaluation and treatment of patients prior to transfer must include the following, whenever indicated:

(1) Establishing and assuring an adequate airway and adequate ventilation;

(2) Initiating control of hemorrhage;

(3) Stabilizing and splinting the spine or fractures;

(4) Establishing and maintaining adequate access routes for fluid administration;

(5) Initiating adequate fluid and/or blood replacement; and

(6) Determining that the patient's vital signs (including blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate perfusion. The vital signs should remain within these parameters for a sufficient time prior to transfer in order that the physician may be reasonably certain that they will not deteriorate while the patient is enroute to the receiving hospital.

There may be times, however, when stabilization of a patient's vital signs is not possible because the hospital or emergency department does not have the appropriate personnel or equipment needed to correct the underlying process (e.g. thoracic surgeon on staff or cardiopulmonary bypass capability). In these cases, steps a. through e. should be performed and transfer should be carried out as quickly as possible.

c. Reaching the Transfer Decision

(1) Evaluate the patient's medical needs.

(2) Determine the adequacy of the medical resources then available at the presenting hospital.

(3) Determine the adequacy of the medical resources then available at the proposed receiving hospital, including the availability of space and qualified personnel for the treatment of the patient.

(4) Evaluate the reasonable risks and benefits to the patient, based upon the information available at the time, and determine whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer.

If the decision is made to transfer the patient to another hospital, then qualified licensed medical personnel must certify compliance with all the requirements of these rules.

(5) Secure commitments from a receiving physician and a receiving hospital, that are both appropriate to the medical needs of the patient, that they will accept responsibility for providing the patient's medical treatment and hospital care.

d. Obtaining the Patient's Consent

(1) Disclose to the patient, or if the patient's physical or mental condition preludes understanding, any other person who may be asked to legally consent in behalf of the patient, accurate and complete information as to each of the five (5) factors analyzed above in section (c) when reaching the transfer decision.

(2) Determine whether the patient's ability to pay for the needed care is at issue and, if so, disclose to the patient, or any other person who may be asked to legally consent in behalf of the patient, information about their eligibility for medical assistance programs of the federal, state or local government and, as to both the hospital initiating the transfer and the receiving facility, the facilities' participation in such medical assistance programs, any obligation upon the facilities to accept the medical assistance program's reimbursement as payment in full for the needed medical care, the availability of indigent care, and any legal obligations to provide medical care without regard to the patient's ability to pay.

(3) Inquire if the patient consents and, if not, re-evaluate the first four (4) factors in step (c) above before initiating an involuntary transfer.

e. Transferring the Patient

(1) Sustain the patient during the transfer.

A physician must be reasonably certain that the patient's condition will not deteriorate while enroute to the receiving hospital. The patient must be transferred in a vehicle that is staffed by appropriately-trained personnel and which contains, when needed, life support equipment. When necessary, the patient must be accompanied by additional specialized personnel from the transferring or receiving hospital.

(2) Supply necessary medical records to the receiving facility.

Necessary medical records are those portions of the patient's medical record which are available and relevant to the transfer and to the continuing care of the patient. The medical records shall include:

(i) identification data;

(ii) information concerning the time of arrival, means and by whom transferrred;

(iii) pertinent history of the injury or illness to include chief complaint and onset of injuries or illness;

(iv) significant physical findings;

(v) all results and/or original records of all diagnostic tests;

(vi) treatment rendered;

(vii) condition of the patient on discharge or transfer;

(viii) diagnosis on discharge.

Any pertinent medical records not transported with the patient during the transfer shall be transmitted to the receiving hospital as soon as possible, but in no event later than forty-eight (48) hours after the transfer.

(3) Maintain a permanent record of the transfer.

All hospitals shall maintain a log recording all transfers, one which separates voluntary and involuntary transfers. Such log shall be kept in a central place, readily available to inspectors, shall fully identify the patients transferred, shall record the facility to which the patient was transferred, and shall record the date of the transfer.

.03. INAPPROPRIATE TRANSFER

a. An inappropriate transfer is any which does not comply with the steps set forth in Section .02, above. With the exceptions set forth in subsection b and c below, inappropriate transfers are prohibited and are good cause for an enforcement action against the responsible hospital.

b. If a patient requests a transfer which is, in the opinion of the treating physician, medically inappropriate, the hospital must comply with the provisions above governing involuntary transfer to the extent that the patient consents to such procedures. If the patient does not consent, the hospital will be deemed to have discharged its obligations under these rules.

c. Transfers made pursuant to a regionalized plan for the delivery of health care services, which has been approved by the department or by other authorized governmental planning agencies, shall be presumed to be appropriate.

d. Discrimination against patients based on race, religion, or national origin is prohibited.

.04. HOSPITAL POLICIES AND PROCEDURES

a. Within 60 days of the effective date of this regulation, the governing body of each hospital must adopt transfer and acceptance policies and procedures in accordance with these rules and the provisions of Tennessee Code Annotated, §68-11-701 through 68-11-705. These policies must include a quality assurance review of all involuntary transfers, with special emphasis on those originating in the emergency room. A hospital which violates a policy made pursuant to these rules also violates these rules and regulations. Until modified, such policies are binding.

b. Transfer agreements with other health care facilities are subject to these statutory and regulatory provisions.

c. When a hospital proceeding in compliance with these rules, seeks to appropriately transfer a patient to another hospital, the proposed receiving hospital may not decline the transfer for reasons related to the patient's ability to pay or source of payment, rather than the patient's need for medical services.

.05. ENFORCEMENT OF THESE RULES

a. Any person or licensee who wishes to complain about a hospital transfer, whether in reference to a specific case or in protest of a hospital policy, may do so by contacting the Department's Licensure Program.

b. Upon receipt of a complaint which, if true, would constitute a violation of these rules, the matter will be investigated by the Department. Upon the hospital's annual inspection, the policies adopted pursuant to §.04, above, will be reviewed, as will be a sample of the involuntary transfers made during the past year.

c. Violations of these rules or of Tennessee Code Annotated, Sections §68-11-701 through 68-11-705, will be formally cited upon a statement of deficiencies provided to the hospital. Within ten days of the hospital's receipt of such a statement of deficiencies, the hospital shall return a plan of correction, indicating the date upon which each deficiency will be corrected. The plan of correction will be individually reviewed and accepted when the plan of correction is an appropriate response to the statement of deficiencies. An unacceptable plan of correction, the failure to submit a plan of correction or the failure to implement appropriate planned corrections may subject the hospital's license to disciplinary action under Tennessee Code Annotated §68-11-207, 68-11-704 and/or 68-11-213.

d. The violation of these rules or the provisions of Tennessee Code Annotated §68-11-701 through 68-11-705 shall be deemed to constitute sufficient grounds to suspend or revoke a hospital's license.

Authority: Tennessee Code Annotated, Sections 68-11-701 to 705 (Public Acts of 1986, Ch. 711), 68-11-209, 68-11-204(b), 68-39-204(a), 68-39-301, 68-39-505, 68-1-103(a), 68-1-802, 68-1-804(4), and 68-1-804(7).

PAA/wm BMF #1

Version #2

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PROPOSED HOSPITAL TRANSFER REGULATIONS

STATEMENT OF REGULATORY SCOPE AND INTENT

It is the intent of these regulations for the Tennessee Board for Licensing Health Care Facilities to promulgate the minimum standards governing the transfer of patients between all licensed hospitals, as is required by Chapter 711 of the Public Acts of 1986. It is also the purpose of these regulations for the Tennessee Department of Health and Environment to publicly declare the policies and procedures under which the Department will review the compliance of those hospitals which participate in the Medicare program with Section 1867 of the Social Security Act, as amended by Section 9121 of the Comprehensive Omnibus Budget Reconciliation Act of 1985. However, should any subsequent amendment to the federal law, regulation later promulgated by the Secretary of Health and Human Services, or policy of that agency conflict with the explicit provision of these rules, then the federal authority will prevail over these rules as to the construction and interpretation of the federal law.

DEFINITIONS AND GENERAL PRINCIPLES

For the purpose of administering these provisions, the Tennessee Department of Health and Environment and the Tennessee Board for Licensing Health Care Facilities now interpret the following terms and declare the following principles:

a. "Hospital" means any facility within the meaning of either Tennessee Code Annotate, Section 68-11-201 (10), or Rule 1200-8-1-.02. The phrase "between hospitals" refers to the transfer of a patient between two (2) "hospitals", however classified, and also refers to the transfer of a patient between a licensed "hospital" and any distinct part or unit of a hospital which is licensed or certified to provide a different level of care.

b. "Transfer" means the movement of a patient between hospitals at the direction of a physician or other qualified medical personnel when a physician is not readily available but does not include such movement of a patient who leaves the facility against medical advice.

Provided, however, the term "transfer" and the provisions of these rules exclude the commitment and movement of mentally ill and mentally retarded persons, whose transfers are governed by Tennessee Code Annotated, Title 33. The term "transfer" does not apply to the discharge or release of a patient who is no longer in medical need of hospital care, nor to a hospital's lawful refusal, after an appropriate medical screening, to render any medical care upon the ground that the person does not have a medical need for hospital care.

c. "Medical emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (A) placing the patient's health in serious jeopardy, (B) serious impairment to bodily functions, or (C) serious disfunction of any bodily organ or part.

d. "Active labor" means labor at a time at which: (A) delivery is imminent, (B) there is inadequate time to effect safe transfer to another hospital prior to delivery, or (C) a transfer may pose a threat to the health and safety of the patient or the unborn child.

e. Emergency Medical Services, hereinafter referred to as "EMS", means the services utilized in responding to the perceived need for immediate medical care in order to prevent loss of life or aggravation of illness or injury.

f. "To stablize" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that the condition will not deteriorate due to the transfer as determined by a physician or other qualified medical personnel when a physician is not readily available.

g. "Patients" includes but is not limited to, any person who is suffering from an acute or chronic illness or injury or who is crippled, convalescent or infirm, or who is in need of obsetetrical, surgical, medical, nursing or supervisory care.

h. Transfers made pursuant to a regionalized plan for the delivery of health care services, which has been approved by the department or by other authorized governmental planning agencies, shall be presumed to be appropriate.

i. Discrimination against patients based on race, religion, or national origin, or economic condition is prohibited.

STEPS IN AN APPROPRIATE TRANSFER

a. Medical Screening Required

Anyone who arrives at a hospital and/or the emergency department of a hospital and who requests or requires an examination or treatment for a medical condition, must be provided an appropriate medical screening examination within the capability of the hospital's emergency department and staff, in order to determine whether or not a medical emergency exists or a woman is in active labor.

b. Stabilizing the Patient

1. Evaluation and treatment of patients prior to transfer must include but not be limited to the following when indicated:

    a. Establishing and assuring an adequate airway and adequate ventilation;

    b. Initiating control of hemorrhage;

    c. Stabilizing and splinting the spine or fractures;

    d. Establishing and maintaining adequate access routes for fluid administration;

    e. Initiating adequate fluid and/or blood replacement; and

    f. Determining that the patient's vital signs (including blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate perfusion.

2. There may be times, however, when stabilization of a patient's vital signs is not possible because the hospital or emergency department does not have the appropriate personnel or equipment needed to correct the underlying process (e.g. thoracic surgeon on staff or cardiopulmonary bypass capability). If a patient at a hospital has not been stabilized or is in active labor, the hospital

a. The patient (or a legally responsible person acting on the patient's behalf) requests that the transfer be effected, or consents to the transfer.

b. A physician, or other appropriate and qualified medical personnel when a physician is not readily available has determined that, based upon the reasonable risk and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another hospital outweigh the increased risk to the individual's medical condition from effecting the transfer.

APPROPRIATE TRANSFER

1. An appropriate transfer to a hospital is a transfer:

   a. in which the receiving hospital (1) has available space and qualified personnel for the treatment of the patient and (2) has agreed to accept transfer of the patient and to provide appropriate medical treatment;

   b. in which the transferring hospital provides the receiving hospital with appropriate medical records, or copies thereof, of the examination and treatment effected at the transferring hospital; and

   c. in which the transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

   d. in which the patient (or a legally responsible person acting on the patient's behalf) requests that the transfer be effected or consents to the transfer.

INVOLUNTARY AND/OR INAPPROPRIATE TRANSFERS

The transfer is involuntary and/or inappropriate when there is no medical reason for the transfer and whenever:

1. The person does not concur with, or consent to, the movement; or

2. The person's physical or mental condition precludes consent and no legally-authorized party consents in behalf of the person; or

3. The person, or the party consenting in their behalf, was given inadequate, incomplete, or misleading information about any of the following:

   i. the medical necessity for the movement.

   ii. the availability of appropriate medical services at the facility initiating the transfer.

   iii the availability of appropiriate medical services at the receiving facility.

   iv. the availability at both the facility initiating the transfer and at the receiving facility of indigent care and the facilities' legal obligations, if any, to provide medical services without regard to the patient's abiltiy to pay.

v. the person's eligibility for medical assistance programs of the federal, state or local government and, at both the facility initiating the transfer and at the receiving facility, the facilities' participation in such programs and, if participating, any obligation to accept the medical assistance program's reimbursement as payment in full for the needed medical care.

4. It is made for purely economic reasons.

ENFORCEMENT OF THESE RULES

a. Any person or licensee who wishes to complain about a hospital transfer, whether in reference to a specific case or in protest of a hospital policy, may do so by contacting the Department's Licensure Program.

b. Upon receipt of a complaint which, if true, would constitute a violation of these rules, the matter will be investigated by the Department. Upon the hospital's annual inspection, the policies adopted pursuant to these regulations, will be reviewed, as will be a sample of the involuntary transfers made during the past year.

c. Violations of these rules or of Tennessee Code Annotated, Sections 68-11-701 through 68-11-705, wil be formally cited upon a statement of deficiencies provided to the hospital. Within ten days of the hospital's receipt of such a statement of deficiencies, the hospital shall return a plan of correction, indicating the date upon which each deficiency will be corrected. The plan of correction will be individually reviewed and accepted when the plan of correction is an appropriate response to the statement of deficiencies. An unacceptable plan of correction, the failure to submit a plan of correction may submit the hospital's license to disciplinary action under Tennessee Code Annotated Section 68-11-207, 68-11-704, and/or 68-11-213.

d. The violation of these rules or the provision of Tennessee Code Annotated Section 68-11-701 through 68-11-705 shall be deemed to constitute sufficient grounds to suspend or revoke a hospital's license.

AS/bb LIC 4

EMERGENCY DEPARTMENT PATIENT 'DUMPING' IN THE MID SOUTH. AL Kellermann, BB Hackman, R Burns. University of Tennessee, Memphis.

Transfer of emergency department (ED) patients because of inability to pay is a serious and growing problem nationwide. To document the extent and nature of this practice in our community, we audited all telephone requests and actual patient transfers from private hospital ED's and affiliated free standing emergency centers to the ED of the Regional Medical Center at Memphis (the Med), a publicly subsidized hospital between June 1 and August 31, 1986. Transfers to the Med's 'special care' areas (burn, high risk obstetrics, neonatal and trauma centers) were assumed to represent tertiary care referrals and were not included. During the 92 day study interval, ED physicians at the Med handled 168 telephone requests for transfer. In 83% of cases, 'no money' or 'no insurance' was given by requesting physicians as the major reason for transfer. Over 40% of requests were refused; half were too unstable or required an intensive care unit (ICU) bed when none were available. Despite telephone screening, the Med ED received a total of 280 transfers during the study period. Two-thirds of these patients arrived without prior telephone authorization, most by private automobile. Almost all (97%) were sent for primarily economic reasons. Nearly one-third were found to be unstable on arrival by explicit clinical criteria. Eighty seven patients (31%) required emergency hospitalization and accounted for 634 bed days during a period of extreme inpatient crowding. Three died prior to discharge. During this same time period, the Med ED transferred out 36 ED patients, including nine eligible for Veteran's Hospital care and ten sent because no ward or ICU bed was vacant at the Med. Many poor or uninsured patients are transferred to crowded public hospitals for non-medical reasons. Telephone screening is necessary but alone is inadequate to safeguard patient welfare. Tough regulations are needed to stop patient 'dumping'.

655 → Dr. Kellerman

TENNESSEE HOSPITAL ASSOCIATION
500 Interstate Blvd. South ● Nashville, Tennessee 37210 ● 615/256-8240

June 12, 1987

TO: Chief Executive Officers

FROM: John K. Miles
Senior Vice President

SUBJECT: Proposed Patient Transfer Regulations
by Health Facilities Licensure Board.
Public Hearings in August

The Board for Licensing Health Care Facilities has just announced firm dates for public hearings on proposed licensure regulations which relate to transfers of patients between hospitals.

All hearings begin at 9:00 AM and the dates and locations are:

1. Memphis - Tuesday, August 11
   1206 State Office Building
2. Knoxville - Thursday, August 13
   U.T. Student Center
   Room 235 (Shiloh Room)
3. Chattanooga - Friday, August 14
   State Office Bldg. Auditorium (McCallie Ave.)
4. Nashville - Tuesday, August 18
   Health and Environment Hearing Room
   287 Plus Park Blvd.

The proposed regulations contain several very specific, and quite restrictive, provisions which need to be fully understood by both medical and executive leaders of Tennessee hospitals.

These proposed regulations, and THA staff comment, will be sent to you within the next few days. In the meantime, please give serious consideration to saving one of these hearing times for a possible presentation in behalf of your hospital.

JKM/mls

SUMMARY OF PROVISIONS OF PROPOSED HOSPITAL TRANSFER REGULATIONS

INTRODUCTION

As many of you are aware, the state transfer regulations, in whatever form they are finally adopted, must be read in conjunction with the federal patient transfer provisions enacted as a part of COBRA by the U. S. Congress in 1986. Accordingly, many of the modifications made in the regulations between the first draft last year and the draft included in this mailing have been directed toward the goal of conforming these state regulations as closely as possible with the already existing federal transfer statute. The federal language has been in effect since August 1986 and it seems logical that, where possible, the state provisions dealing with the same issue should track the federal language as much as practicable.

Without dwelling on the provisions of the federal statute, suffice it to say that there are several significant areas of difference between the draft state regulations and the federal transfer statute. Although there is no legal requirement by any means that the state regulations track the federal statute, it seems reasonable to suggest that there be one uniform set of guidelines for dealing with transfer decisions in order to prevent confusion and misapplication of the rules by emergency room personnel.

SUMMARY

I. The first section of the rules is entitled "Statement of Regulatory Scope and Intent." This section merely provides that the regulations are promulgated pursuant to the requirements of the 1986 state transfer legislation and that in the event of a conflict between these rules and the federal COBRA transfer provisions, the federal statute shall prevail.

II. The next section of the draft is entitled "Definitions and General Principles." Several of the definitions are worthy of closer attention. The term "transfer" is defined as any physical movement of a patient between hospitals at the direction of a physician or other medical personnel. Thus, under this definition, any transfer of a patient, whether the patient was in a stable medical condition or not, would be subject to the scope of the regulations. The terms "medical emergency" and "active labor" parallel the equivalent federal COBRA definitions of these terms. These two terms set out the conditions which trigger the regulations requirement that patients be screened and treated when presenting at the hospital complaining of one of the above conditions. Paragraph "f" of this section defines the term "to stablilize." This is an extremely important provision of the regulations. In essence it provides that a patient is stable if his medical condition will not deteriorate in the event of a transfer to another facility.

III. The next section of the regulations is the key substantive provision of the proposal and is entitled "Steps in an Appropriate Transfer." Paragraph "a" provides that anyone who presents himself at a hospital and who requests a medical examination or treatment must be provided an appropriate medical screening examination, within the capability of the institution, to determine whether or not a medical emergency exists or a woman is in active labor. Paragraph "b" provides that prior to transfer a patient must be stabilized and sets out at a minimum several medical procedures which should be initiated where appropriate to effect the stabilization of the patient's condition. This subsection also provides that where a patient cannot be stabilized because of inadequate personnel or equipment at the presenting facility, the hospital may transfer the patient to another facility only if either (a) the patient or a legally responsible person acting on his behalf requests or consents to a transfer or (b) a physician determines that the medical benefits derived from transferring the patient to a more appropriate treating facility outweigh the increased risk to the patient's medical condition from being transferred.

IV. The next section of the regulations is titled "Appropriate Transfer" and lists the attributes of such a transfer. In order for a transfer to be appropriate under the regulations, the receiving hospital must be qualified to treat the patient, have space available for such treatment, and have agreed to accept the transfer. Also, the transferring hospital is obligated to provide the receiving facility appropriate medical records and to see to it that the transfer is effected through the use of qualified personnel and transportation equipment including any necessary life support measures during the transfer. Further, this section provides that if a patient requests a transfer or consents to such a movement, the transfer is appropriate.

V. The next section of the regulations is titled "Involuntary and/or Inappropriate Transfers", and it sets out various attributes of such improper transfers. The section provides that a transfer is involuntary and/or inappropriate when there is no medical reason for the transfer and either the person failed to consent to the movement or the patient's consent was based on inadequate, incomplete, or misleading information about (1) the medical necessity for the movement, (2) the availability of services to treat the patient at the transferring facility, (3) the availability of appropriate medical services at the receiving facility, (4) the availability at both the transferring and the receiving hospital of funding for indigent care, and (5) the person's eligibility for medical assistance programs offered by any unit of government at both the receiving and the transferring facility. Finally, this section makes it clear that a transfer for purely economic reasons is inappropriate.

VI. The last section of the rules is entitled "Enforcement of these Rules" and relates to investigatory powers and penalties associated with alleged violations of the provisions.

CONCLUSION

In conclusion, and in an admittedly very rough paraphrase, the rules provide that a patient in an unstable condition may not be transferred unless there is medical justification outweighing the risk of the transfer *or* unless the patient consents to be transferred. Although the rules are not wholly unambigious on this point, the clear implication of the text is that a stabilized patient, i.e. one who by definition will not suffer medical deterioration as a result of being transferred, may also not be transferred unless he consents to the movement. The blanket prohibition against economically based transfers applies without regard to whether or not the patient's condition has been stabilized, i.e. without regard to whether or not the patient's medical condition will be adversely affected by a transfer. As drafted, it would appear that the regulations speak to transfer situations other than those which have adverse patient care implications.

TENNESSEE HOSPITAL ASSOCIATION
500 Interstate Blvd. South • Nashville, Tennessee 37210 • 615/256-8240

MEMORANDUM

TO: Chief Executive Officers of Member Institutions

FROM: Charlie Cato

DATE: June 18, 1987

SUBJ: Draft Transfer Regulations

Enclosed with this memo is a copy of the latest draft of the hospital transfer regulations, dated April 28, 1987, now pending before the Health Care Licensing Board. Last week we provided you with notification of the public hearing dates scheduled across the state in August for receipt of public comment and testimony regarding the draft regulations. (In the event you have misplaced last week's notice, a copy of it is also enclosed with this mailing.) We indicated to you in our earlier communication that a copy of the draft regulations as well as a staff analysis of their provisions would be forthcoming. Accordingly, this memo contains that recapitulation of the provisions of the draft regulations.

Briefly by way of background, most of you are aware that the Tennessee General Assembly enacted legislation in the 1986 session dealing with the issue of patient transfers. As originally introduced, the 1986 enactment, sponsored by Senator John Ford of Memphis, would have placed into the Code a fairly specific and detailed procedure for handling patient transfers between hospitals. The original bill as introduced was patterned after legislation which had been adopted in Texas relating to the transfer issue. As a result of amendments to the legislation as it progressed through the legislative process, the final version of the bill did not enact specific transfer provisions. Rather, it instructed the Health Care Licensing Board to promulgate regulations dealing with patient transfers and included several criteria which were to be addressed in the regulations.

Shortly after passage of the 1986 act, the Licensing Board membership and its staff began the lengthy process of devising regulations to speak to the patient transfer question. The Board appointed a task force of its membership, chaired by administrator David Dunlap, to assist in the preparation of the regulations. An initial set of regulations went out for public hearing in October 1986. In response to comments received at the initial public hearing and at subsequent Board meetings, as well as statements from members of the Board itself, various draft regulations have been circulated during the intervening months. The Board has considered the regulations at one time or another during each of its meetings held subsequent to the October 1986 public hearing.

In addition, the Board appointed task force has met on several occasions to grapple with the specific provisions of the regulations.

Because the draft included in this mailing varies so significantly from the initial draft which went to public hearing in October of last year, the Board, acting at its most recent meeting, determined that it would be prudent to send the revised draft out for further public comment prior to its adoption by the Board, possibly at the September 9-10 Board meeting. Although patient transfer questions may arise more frequently in an urban setting as opposed to a rural area where there are a limited number of hospital providers, we feel that this issue should be of enough significance to all members of THA to warrant taking time to develop and present your comments and testimony to the public hearing scheduled in your geographic vicinity. In order to assist you in preparing such testimony as you feel appropriate, staff is providing you with the enclosed analysis of the regulations as well as a copy of the draft regulations themselves.

If any of you have any questions about any of the material included in this mailing, please feel free to contact us at THA for a further clarification. Also, be advised that comments can be made to the Board either in person at the hearing scheduled in your area or by written remarks forwarded to the staff of the Board. Even if you appear in person, it is preferable to provide the staff a written summary or transcript of your oral remarks for further consideration by the Board as it deals with this issue. In either event, please send us at THA a copy of whatever remarks you may deliver to the Board on this issue so that we can be aware of member reaction to these regulations.

msc

PROPOSED

REGIONAL MEDICAL CENTER
AT MEMPHIS
Emergency Department

PATIENT TRANSFER POLICY

Statement of Intent

The Emergency Department of the Regional Medical Center will continue to accept patients regardless of their means. This policy is adopted to safeguard the health of those patients who are transferred from the emergency departments of other hospitals to our hospital for purely economic reasons.

This policy specifically covers transfers to THE MED's Emergency Department only. It does not affect transfers to other departments such as the Obstetrical Unit at E. H. Crump Women's Hospital, the Elvis Presley Memorial Trauma Center, Neonatal Intensive Care Unit, or Burn Unit.

Procedure for Transfer of Patients

Step 1. Telephone call.

The transferring hospital will call the MED's Emergency Department and provide the following information about the patient being proposed for transfer:

a. Medical screening results.

Give results of a medical screening examination performed by a physician or other appropriate and qualified medical personnel when a physician is not readily available to determine whether a medical emergency exists or a women is in active labor. This medical evaluation will also include an assessment of stabilization of the patient's vital signs (including blood pressure, pulse, respiration, urinary output - if indicated).

b. Informed consent.

Indicate to MED Emergency Department personnel whether the patient has been appropriately informed of reasons for transfer and if medical personnel and patient have signed the informed consent form provided.

Step 2. Acceptance of patient transfer. THE MED will accept for transfer all Shelby County residents who are being transferred for primarily economic reasons if the following conditions are met:

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a. THE MED has vacant beds and qualified personnel for the treatment of the patient, and gives its consent for the transfer.

b. Step 1 of the procedure for transferring patients has been followed. Informed consent of the patient is not required where the transfer is an emergency transfer of an incompetent patient requiring tertiary services unavailable at the transferring facility, and where delay in obtaining informed consent will result in further impairing the patient's condition.

c. Patient is stabilized. If a patient at a hospital has not been stabilized or is in active labor, THE MED's Emergency Department will not accept a transfer unless a physician, or other appropriate and qualified medical personnel, if a physician is not readily available, has determined that based upon a judgement of reasonable risks and benefits to the patient, the medical benefits reasonably expected from the transfer to THE MED, outweigh the increased risk to the patient. Informed consent of the patient is not required for such transfers.

d. The transferring hospital agrees to provide THE MED's Emergency Department with appropriate medical records or copies thereof, of the examination and treatment effected at the transferring hospital.

e. The transferring hospital agrees to transfer the patient by qualified personnel and transportation equipment as required, including the use of necessary and medically appropriate life support measures during the transfer.

Transfers which are inconsistent with this policy

Attempted transfers of patients in a manner inconsistent with this policy will be refused. Transfers of patients made to THE MED's Emergency Department over its refusal or in a manner otherwise inconsistent with this policy such as, patients referred on an emergency basis by automobile without prior notification to THE MED's Emergency Department, will be reviewed by the Regional Medical Center at Memphis, and referred to state, federal, and professional boards or agencies for licensing, accreditation and funding of health care institutions as appropriate.

Emergency Department

Patient Transfer Informed Consent Form

This form must be completed for every Shelby County resident who is to be transferred to the Regional Medical Center's Emergency Department for primarily economic reasons. There is no need to complete this form for the transfer of patients who are transferred because of a medical emergency.

==

Patient Consent

I, ____, understand and have been
(printed name of patient)
informed that ____________________________ hospital intends to move me to the Regional Medical Center at Memphis for treatment. I have been informed of the availability of appropriate medical services, both at the Regional Medical Center and transferring hospital.

I further understand that the care I need:

(check one)

_____is not available to patients at the transferring hospital.

OR

_____is available, but I am being transferred for primarily economic reasons.

(check one)

_____I agree to be responsible for the ambulance fees.

OR

_____The transferring hospital agrees to be responsible for the ambulance fees.

I understand that I will be billed for emergency room and inpatient care at the Regional Medical Center at Memphis.

I consent to my transfer to the Emergency Department of the Regional Medical Center at Memphis for treatment.

____
Signature (Patient or Guardian)

____
Patient's or Guardian's name & relationship to patient
(please print)

____
Date

==

Physician Certification

I, ____________________________, affirm that ______________________, a patient who has presented him/herself for treatment at _______________________________ hospital has been examined and evaluated, and that his/her condition is stable and the transfer of this patient will not compromise his/her medical condition, that I have contacted Dr. ________________________ of the Emergency Department of the Regional Medical Center and agreement to accept the transfer of this patient has been given to me. Further, I affirm that this patient's medical record of copies thereof will accompany the patient being transferred and that said patient will be transferred by qualified personnel and transportation equipment as required, including the use of necessary and medically appropriate life support measures during the transfer. The patient has been informed of the risks and benefits of the transfer and has consented.

____
Physician's Signature

____
Physician's Name (please print)

____
Date

5/18/87
Draft

THE MED

MEMORANDUM

TO: Dr. Arthur Kellerman
Dr. James Brown

FROM: Gary S. Shorb, President Gary

SUBJECT: **Patient Transfers**

DATE: June 23, 1986

Attached is an analysis of the new federal constraints regarding transfers of emergency patients; one was prepared by the National Association of Public Hospitals and one by The Tennessee Hospital Association. This legislation should prove very helpful to us and I want to insure that any case of what appears to be a violation of this law be pursued as diligently as possible.

This statute is effective on August 1, 1986. By copy of this memo, I am asking Jack Young and Larry Truly to summarize this bill in a letter format that either of you can send to all emergency rooms in the region. We may want to re-emphasize the fact that we will be recording all requests for transfers.

GSS/se

cc: Executive Staff

[illegible]

Ray Colson Coll Med.

REGIONAL MEDICAL CENTER AT MEMPHIS
877 Jefferson Avenue, Memphis, Tennessee 38103

Call writer direct

EMERGENCY DEPARTMENT TRANSFER AND ADMISSION POLICY

REGIONAL MEDICAL CENTER AT MEMPHIS

INTRODUCTION

The principal mission of the MED Emergency Department (ED) is to provide emergency medical care to any seriously ill individual, regardless of their ability to pay. True emergency patients presenting to any E.R. should not be refused care under any circumstances.

'Urgent' and 'Emergent' patients requiring emergency inpatient care will be admitted to the hospital with minimal delay, especially if they are residents of Shelby County. Patients who can be returned for an elective/scheduled admission and patients who can have their evaluation and care managed as an outpatient should not be admitted on an emergency basis.

Seriously ill or injured patients presenting to the Med will receive appropriate and timely medical care, including hospital admission, regardless of their county and state of origin and regardless of their ability to pay. The following protocol applies to patients being transferred to the Med or from the Med to other health care insititutions.

1. ER TRANSFER TO 'THE MED'

The Regional Medical Center at Memphis is the major regional referral center for trauma, burns and high risk obstetrics. 'The Med' also provides virtually all of the inpatient care for the poor and uninsured of Shelby County under a long standing agreement with Shelby County government.

The following ER transfer policy is structured with two primary responsibilities in mind:

1) Major trauma, burns and high risk obstetric referrals carry highest priority in periods of limited bed availability.
2) Indigent Shelby County residents potentially requiring inpatient care are often transferred to the Med for evaluation and possible admission. At present, we will continue to honor all such requests for emergency transfer unless:

    a) The patient is too unstable for transport and adequate services are available at the transferring hospital.
    b) The patient is a non-Shelby County resident and does not require the specialized services that are only available at the Med.
    c) The patient requires an ICU bed and none are available at the Med in the MICU, SICU or TICU. (Note: When less than three ICU beds are open, transfer of cases other than trauma or burns should not be accepted.*)
    d) The patient requires admission to a hospital and less than six 'Med" floor beds are available. The number of 'available' floor beds will be determined by subtracting the number of emergency room patients pending hospital admission from the number of 'open' beds indicated on the bed control computer (regardless of whether the bed has been vacated or not). 'Step-down' beds will not be included in this count.*
    e) Transfer of patients from Arkansas or Mississippi (ie, non Shelby County residents) should not be accepted unless the patient requires tertiary care not available at the transferring hospital and alternative private hospitals refuse care. All non-trauma transfers should be carefully documented and the ER director should be notified.
    f) All telephone requests for transfer should be taped and carefully noted in the ED transfer log, regardless of whether the patient is ultimately accepted or not.
    g) The ER director should be notified of any ER patient transfers to the Med who arrive without prior authorization.

*the ER director (or designee) must be notified and approve any decision to 'close' the Med ER to hospital transfers.

2. ER TRANSFERS FROM 'THE MED'

Medically indigent, out-of-state and out of Shelby county patients may be transferred to another facility only if:

a) the patient is stable and requests or agrees to transfer;
b) the receiving hospital has been contacted and agrees to the transfer;
c) the receiving hospital offers to provide the patient with appropriate medical care.

All transfers of patients from the Med to another hospital require approval of the duty administrator and the ER Director prior to transfer unless: a) the patient requests transfer and has insurance b) the patient's private physician requests transfer and the patient agrees or c) the patient is a veteran and the VA accepts transfer.

CASE # ___ ___ ___ ___

AMBULANCE TRANSFER DATASHEET

PATIENT NAME: ____________________ (Last) ______________ (First) ____ (MI)

MD TAKING CALL: ______________________________

MD REQUESTING TRANSFER: ______________________________

HOSPITAL REQUESTING TRANSFER: ______________________________

DATE: __ __ / __ __ / 8 7

TIME CALL RECEIVED _____ : _____ AM / PM (00:00 = NO CALL)

PATIENT'S PROBLEM ______________________________

____

____

REASON TRANSFER TO MED REQUESTED (CHECK ONE):

( ) INDIGENT PATIENT (IE 'NO INSURANCE', 'NO MONEY', ETC...)

( ) NO BEDS AT ALL IN TRANSFERRING HOSPITAL

( ) NO 'CHARITY SERVICE' BEDS IN TRANSFERRING HOSPITAL

( ) PATIENT REQUIRES SPECIALITY CARE NOT AVAILABLE AT TRANSFERRING HOSPITAL TO ANY PATIENT, REGARDLESS OF ABILITY TO PAY

( ) PATIENT REQUESTS TRANSFER (PER TRANSFERRING MD)

( ) PATIENT SENT WITHOUT REQUESTING PHONE CALL

( ) OTHER (SPECIFY) ______________________________

TRANSFER ACCEPTED? ( ) YES ( ) NO

IF REFUSED, REASON REFUSED: (CHECK ONE)

( ) PATIENT TOO UNSTABLE FOR TRANSFER

( ) NO AVAILABLE FLOOR BEDS

( ) NO AVAILABLE ICU BEDS

( ) NON TENNESSEE RESIDENT

( ) TENN/NON-SHELBY COUNTY RESIDENT

( ) NOT APPROPRIATE FOR THE MED (E.G. PATIENT WANTS DRUG REHABILITATION)

( ) OTHER REASON (SPECIFY) ______________________________

PATIENT TRANSFERRED DESPITE REFUSAL? ( ) YES ( ) NO

PATIENT'S MEDICAL RECORD NUMBER: ___ ___ ___ ___ ___ ___ ___

PATIENT'S UNIT #: ___ ___ ___ ___ ___ ___ ___

NOTE: IF YOU ARE TRANSFERRING A PATIENT TO ANOTHER HOSPITAL, PLEASE COMPLETE THE BACK SIDE OF THIS PAGE.

JUN 1 8 [illegible]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Analysis & Inspections
Region VI - Dallas, Texas

Room 4E6 *1100 Commerce St.* *Dallas, Texas 75242*

15 JUN 1987

Gary Shorb, Director
Memphis Regional Medical Center
877 Jefferson Avenue
Memphis, Tennessee 38103

Dear Mr. Shorb:

Thank you for agreeing to participate in our study concerning emergency room patient dumping. The impetus to our study was, among others, the anti-dumping provisions included in the Consolidated Omnibus Reconciliation Act (COBRA) of 1986. As you are probably aware, the law was signed in April 1986, and the provisions became effective in August 1986 (I have enclosed a copy of the provisions for you information).

The purpose of this study is to obtain advice and suggestions of public hospital administration and medical staff on types of information and procedures needed to effectively implement and monitor the provisions COBRA. To achieve this purpose, we would like to conduct separate confidential interviews with you, your emergency room administrator, your emergency room medical director, and your emergency room triage nurse. We expect the interviews to last about an hour each.

We will be interesting in, and asking questions related to these areas:

Educational efforts to inform hospitals, physicians, or patients about COBRA.

Record keeping procedures, statistics, trends, and problem indicators.

Development of transfer protocols on emergency patients.

Cooperative hospital community efforts to address the emergency room patient dumping problem.

Page 2 - Mr. Gary Shorb

In this regard, please identify any summary records, transfer procedures, protocols, or Best Practices you have developed to deal with the dumping problem internally or within the community. We have enclosed a list of questions related to these issues that we hope you can complete and provide during our visit.

Mr. Frank Almendarez, of my staff, will be at your hospital from noon, June 23, untill 5 p.m., June 24. He can conduct the interviews at any time during this core period of time.

We're looking foward to our visit, and once again, thank you for you're interest and participation. If you have any question pertaining to this letter or if you have problems scheduling the interviews, please call Kevin Golladay or Frank Almendarez at (214) 767-3310.

Sincerely,

Ralph Tunnell
Regional Inspector General
for Analysis and Inspections

Enclosures

STATISTICAL INFORMATION

Hospital bed size __________ County population __________

As a percentage of gross revenue from patient care, what is the percentage of deductions for bad debt and charity care (uncompensated care)? ____________

At your facility what is the gap between the revenues received to compensate for charity care and the deductions for uncompensated care?

Revenues for charity care __________
Cost of charity care __________
Difference __________

What is the average monthly patient volume of your Emergency Room? ________

What is the average monthly volume of transfers through the ER? ___________

What is the average monthly number of patients you feel are transferred to you in an unstable condition? _____________

What is the average number of transfers per month which are not in compliance with your transfer guidelines? __________

What is the average number of patients transferred each month without prior notice? _____________

What is the average monthly volume of transfer cases which are treated at the emergency room and released? This situation lays strong doubt as to the medical necessity of the transfer.

____

What is the number of transferred patients who died within a 48 hour period after transfer to your hospital for the period June 1, 1986 to May 31, 1987? ___________

Please provide us with copies of any transfer agreements you have with community hospitals.

Please provide us with copies of any studies or statistics you may conducted or collected related to the transfer of emergent patients.

How many times throughout the past year have you not had available space or staff to care for the transferred emergency patients?

Dr. K -

Per your request

Gary

TABLE 27
NET REVENUE OF NONFEDERAL HOSPITALS
HSA VI, TN, 1983 - 1985

Hospital	Net Revenue 1		
	1983	1984	1985
Baptist Hospitals	$23,343,925	$32,727,788	$17,221,047
Baptist Specialty		501,176	(348,468)
Eastwood	196,400	(92,444)	6,938,000
Lakeside	1,750,735	1,796,514	1,259,928
Le Bonheur	950,122	52,971	2,836,007
MMHI	5,308,756	4,436,486	5,878,957
Methodist Hospitals	12,858,000	14,364,410	27,346,105
Mid-South			2,237,992
Regional Med. Ctr.	(3,723,522)	(6,092,420)	(2,989,045)
St. Francis	8,807,421	8,623,804	6,839,150
St. Joseph	(175,041)	38,294	3,955,096
St. Jude	4,434,437	3,498,585	263,447
Univ. of Tennessee	508,600	992,623	445,695
SHELBY CO. TOTAL	$54,259,833	$60,847,787	$71,883,911
Baptist-Lauderdale	(134,269)	125,305	(1,223,188)
Baptist-Tipton	41,440	632,105	(701,248)
Methodist-Somerville	(71,586)	187,000	(297,452)
RURAL CO. TOTAL	($164,415)	$944,410	($2,221,888)
HSA VI TOTAL	$54,095,418	$61,792,197	$69,662,023

1 Net revenue = gross charges + all other revenue - adjustments - operating costs - depreciation

SOURCE: Joint Annual Report of Hospitals, 1983 - 1985, Tennessee Department of Health and Environment.

MEMPHIS, SATURDAY, APRIL 25, 1987 THE COMMERCIAL APPEAL

'Patient dumping' rules face review

Med backs tougher regulations

By Stephen G. Tompkins
Staff Reporter

Regulations that would ban transfers of patients from hospital to hospital because they cannot pay their bills are scheduled for final review by the Tennessee Board for Licensing Health Care Facilities next week.

It appears executives from The Regional Medical Center at Memphis and representatives of the Tennessee Hospital Association may clash on the issue during the meeting in Nashville Thursday.

The rules prohibit a hospital from transferring patients to another hospital just because they are poor or uninsured.

"The transfer is involuntary and/or inappropriate when there is no medical reason for the transfer and whenever it is made for purely economic reasons," the proposed regulations say.

Violations of the regulations could mean the suspension or revocation of a hospital's license.

Executives from The Med have pushed for the restrictions and plan to attend the hearing. "We've heard rumors that the Tennessee Hospital Association may oppose these new regs," said Gary Shorb, president of The Med.

Dr. Edward W. Reed, a Memphis surgeon and board chairman at The Med, compared those regulations to the civil rights laws of the 1960s: "Just like the civil rights laws, these regulations will stimulate the consciousness of the people who control hospitals.

"We will never stop patient dumping unless we change our philosophical thinking," Dr. Reed said.

However, Charles Cato, Tennessee Hospital Association corporate counsel, said THA is opposed to the provision that prohibits hospitals from transferring a patient for economic reasons.

Cato said THA agrees that the regulations should cover all hospital patients and that every patient must be treated and stabilized when entering a hospital.

"Our goal has always been to see to it that the movement of patients from one hospital to another when the patient is in some sort of life-threatening circumstance stops," Cato said. "But if the transfer is not going to worsen the patient's medical condition, and if in fact they are stabilized, then I don't see the rationale for regulations beyond that point."

Highlights of the new regulations include:

- Every patient who requires treatment "must be provided an appropriate medical screening examination within the capability of the hospital's emergency department and staff," to determine if a "medical emergency exists or a woman is in active labor."
- A patient must then be stabilized, which includes controling hemorrhaging, splinting fractures, and checking vital signs for a life-threatening situation.
- A transfer is authorized if the patient agrees to the transfer, the receiving hospital has available space and qualified personnel to treat the patient, and agrees to accept the transfer.

10-A ● THE TENNESSEAN • Thursday/APRIL 30, 1987

EDITORIALS

THE TENNESSEAN

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A GANNETT NEWSPAPER

Regulations should stop dumping of poor patients

THIS week, a state board will discuss "dumping" — not the dumping of nuclear waste or other hazardous matter, but the dumping of people.

"Dumping" is the term used when poor people are moved from one health care facility to another because they can't pay and have no insurance. The state Board for Licensing Health Care Facilities is scheduled to consider this week proposed regulations concerning patient dumping.

This problem was addressed last year when the board passed regulations on the treatment of poor or uninsured patients by hospitals. Those regulations were good, but they were far from complete because they only covered in-patient treatment and not emergency room patients.

At a hearing last November, Dr. Arthur Kellerman, the emergency room director at Memphis' Regional Medical Center, testified that 286 patients were dumped on his facility, which is public, over three months last summer. Dr. Kellerman estimated that 95% of those patients were dumped "primarily for economic reasons."

More that 30% were physically unstable at the time of the transfer. In two-thirds of the cases, the transferring facilities didn't even telephone the other hospitals to tell them about the patients.

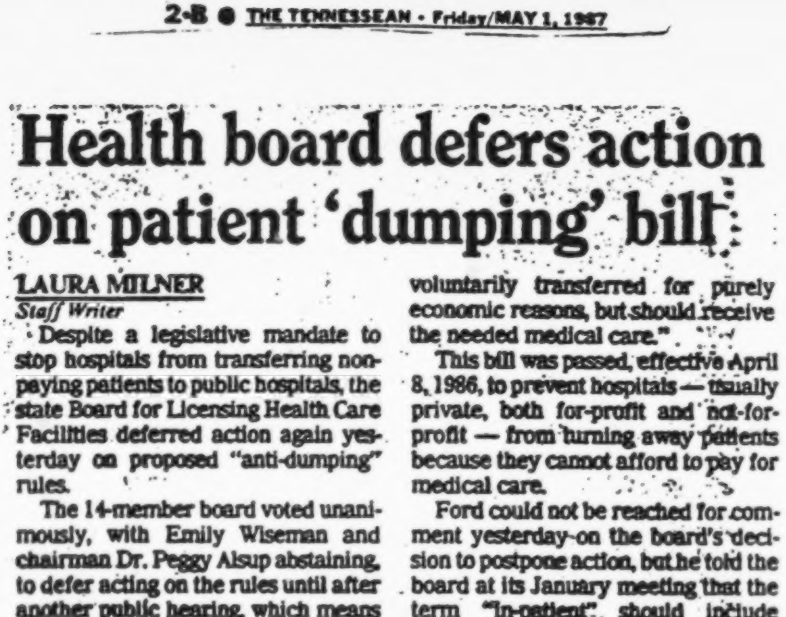
The proposed regulations would require hospitals to provide "appropriate medical screening" for patients who need emergency care or pregnant women in labor. The patients would be evaluated and treated to assure they were breathing adequately, that they weren't hemorrhaging, that all broken bones had been treated, and that their vital signs were stable.

Then before a patient could be moved, the transferring hospital would be required to telephone the admitting facility to be sure there were available resources and space. It would provide the other facility with medical records and any other information on the patient's condition. The regulations also require qualified personnel and appropriate equipment to be used to transfer the patient.

It's a little disconcerting that health care professionals need to be told not to move patients who are medically unstable or who are about to give birth. And it is very disconcerting that any health care facility would check an individual's insurance coverage before checking his vital signs. But it can and does happen.

Questions are sometimes raised about the ties between the Board for Licensing Health Care Facilities and the hospital industry. But surely all the board members and all the hospitals in Tennessee can agree on the benefits of these common sense, humane regulations.

Gov. Ned McWherter made a giant step in solving the state's indigent health care problem earlier this year when he expanded Medicaid coverage. The board's acceptance of these regulations would be another big step. ■



2-B • THE TENNESSEAN • Friday/MAY 1, 1987

Health board defers action on patient 'dumping' bill

LAURA MILNER
Staff Writer

Despite a legislative mandate to stop hospitals from transferring nonpaying patients to public hospitals, the state Board for Licensing Health Care Facilities deferred action again yesterday on proposed "anti-dumping" rules.

The 14-member board voted unanimously, with Emily Wiseman and chairman Dr. Peggy Alsup abstaining, to defer acting on the rules until after another public hearing, which means no new regulations will be approved until July or September.

"The regulations would have ensured the protection of each patient," said Gary Shorb, administrator of the Regional Medical Center of Memphis.

"Economics, from our vantage point, was not the issue. The issue was making sure patients are stabilized and able to give their consent before being transferred from one hospital to another."

Sen. John Ford, D-Memphis, sponsored the bill last year that requires the state licensing board to adopt rules regulating "the transfer of in-patients between hospitals and that in-patients should not henceforth be involuntarily transferred for purely economic reasons, but should receive the needed medical care."

This bill was passed, effective April 8, 1986, to prevent hospitals — usually private, both for-profit and not-for-profit — from turning away patients because they cannot afford to pay for medical care.

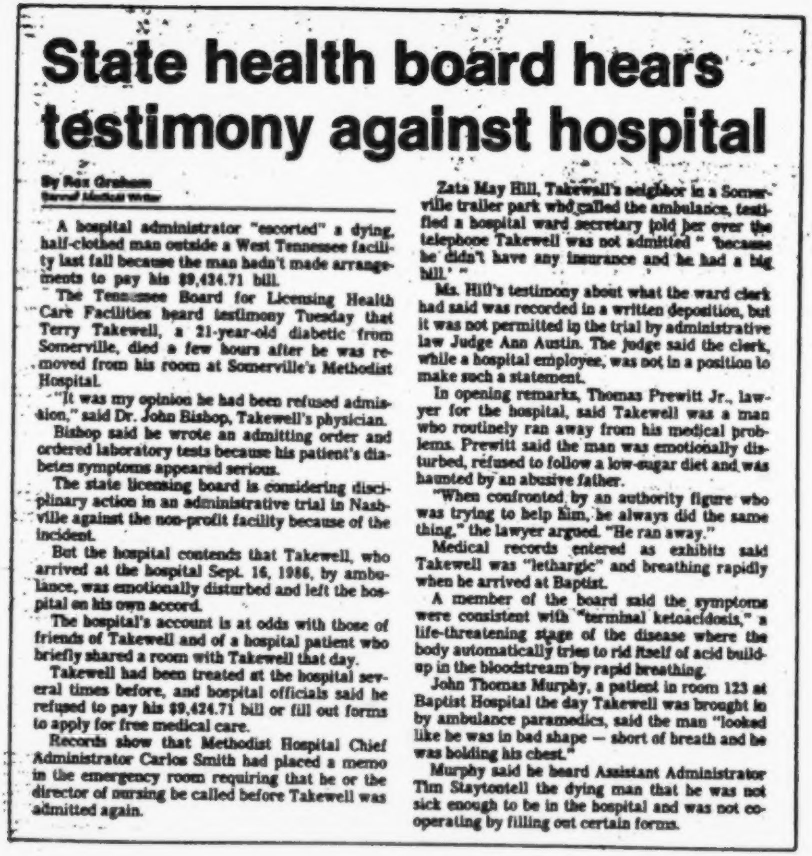
Ford could not be reached for comment yesterday on the board's decision to postpone action, but he told the board at its January meeting that the term "in-patient" should include emergency-room patients.

"The bill is no good unless the emergency room is included in the regulations," Ford told the board.

He said that if emergency room patients were not included, hospitals would be less likely than ever to admit an indigent patient who initially seeks emergency treatment.

After months of debate, a board subcommittee rewrote the rules to protect emergency room patients and other hospital patients from being transferred for non-medical reasons.

But the board fell short yesterday of adopting its own regulations, and postponed implementation for six months to a year. ■



State health board hears testimony against hospital

By Rex Graham
Banner Medical Writer

A hospital administrator "escorted" a dying, half-clothed man outside a West Tennessee facility last fall because the man hadn't made arrangements to pay his $9,424.71 bill.

The Tennessee Board for Licensing Health Care Facilities heard testimony Tuesday that Terry Takewell, a 21-year-old diabetic from Somerville, died a few hours after he was removed from his room at Somerville's Methodist Hospital.

"It was my opinion he had been refused admission," said Dr. John Bishop, Takewell's physician.

Bishop said he wrote an admitting order and ordered laboratory tests because his patient's diabetes symptoms appeared serious.

The state licensing board is considering disciplinary action in an administrative trial in Nashville against the non-profit facility because of the incident.

But the hospital contends that Takewell, who arrived at the hospital Sept. 16, 1986, by ambulance, was emotionally disturbed and left the hospital on his own accord.

The hospital's account is at odds with those of friends of Takewell and of a hospital patient who briefly shared a room with Takewell that day.

Takewell had been treated at the hospital several times before, and hospital officials said he refused to pay his $9,424.71 bill or fill out forms to apply for free medical care.

Records show that Methodist Hospital Chief Administrator Carlos Smith had placed a memo in the emergency room requiring that he or the director of nursing be called before Takewell was admitted again.

Zata May Hill, Takewell's neighbor in a Somerville trailer park who called the ambulance, testified a hospital ward secretary told her over the telephone Takewell was not admitted " 'because he didn't have any insurance and he had a big bill.' "

Ms. Hill's testimony about what the ward clerk had said was recorded in a written deposition, but it was not permitted in the trial by administrative law Judge Ann Austin. The judge said the clerk, while a hospital employee, was not in a position to make such a statement.

In opening remarks, Thomas Prewitt Jr., lawyer for the hospital, said Takewell was a man who routinely ran away from his medical problems. Prewitt said the man was emotionally disturbed, refused to follow a low-sugar diet and was haunted by an abusive father.

"When confronted by an authority figure who was trying to help him, he always did the same thing," the lawyer argued. "He ran away."

Medical records entered as exhibits said Takewell was "lethargic" and breathing rapidly when he arrived at Baptist.

A member of the board said the symptoms were consistent with "terminal ketoacidosis," a life-threatening stage of the disease where the body automatically tries to rid itself of acid build-up in the bloodstream by rapid breathing.

John Thomas Murphy, a patient in room 123 at Baptist Hospital the day Takewell was brought in by ambulance paramedics, said the man "looked like he was in bad shape — short of breath and he was holding his chest."

Murphy said he heard Assistant Administrator Tim Staytontell the dying man that he was not sick enough to be in the hospital and was not cooperating by filling out certain forms.

NAPH 1987 MEMBER PROFILE

REGIONAL MEDICAL CENTER AT MEMPHIS

THE MED, 877 JEFFERSON AVENUE, MEMPHIS, TENNESSEE 38103
(901) 575-7100

Memphis, center of the Mid-South, needed a hospital in the early 19th century less for its 700 inhabitants than for the hundreds of sick travelers on the Mississippi river. So Memphis Hospital, the earliest known hospital in the state of Tennessee, was chartered in 1829 in the hospice tradition, as a place for the weary and ill to rest before continuing on their journey.

As Memphis changed into a regional capital of commerce and culture, so changed its public hospital. The three story eight-room two-physician brick hospital which opened in 1841 in a beautiful grove near the river and served as a military hospital in the Civil War became Memphis General Hospital at the end of the century. For fifty years and into the 1980s, this hospital struggled to serve the city's poor, as well as needy patients from other southern states and other parts of Tennessee. As the site of the beginning of clinical teaching in the state, it developed a series of satellite hospitals and specialty services for the whole community.

DATA

ADMISSIONS
21,573

EMERGENCY ROOM VISITS
60,000

OUTPATIENT VISITS
98,500

NUMBER OF CLINICS
27

NUMBER OF BEDS
450

NUMBER OF EMPLOYEES
2,400

DISTINGUISHING FEATURES
Centers of Excellence; Restructuring; Public Relations

CONTACT
Gary Shorb
President

The entire complex was restructured and rechristened in 1983. Today's Regional Medical Center at Memphis—The Med—is centered in a new $60 million 244-bed hospital.

Operating on an $87 million annual budget, and training some 900 people a year from chaplains to nurses and residents, The Med aims to provide a network of comprehensive services to all the people of Shelby County and the Mid-South.

The Med's contemporary approach, publicized through a successful advertising campaign, has made the Memphis community, and the broader hospital community, aware of its four Centers of Excellence:

The *Elvis Presley Memorial Trauma Center*, a combination emergency room, operating room, intensive care unit, blood bank and laboratory. The only Level I Trauma Center in the Mid-South, it is staffed by two teams of specialists working 24-hour shifts. Victims usually brought in by helicopter or ambulance are treated by specially trained doctors, nurses and skilled technicians.

The *Burn Unit*, serving a 150 mile radius, is staffed and equipped to handle the most severe burn cases, trying not only to save, but to repair lives.

The *High-Risk Obstetrics Center*delivers fully half of all the babies born in Shelby County each year and 10% of those born in Tennessee. Pregnant women find the special services required by such complicating factors as age, diabetes, and hypertension. A certified nurse-midwives program emphasizes family-centered childbirth.

(Continued on back)

The large *Newborn Center* offers the entire spectrum of pediatric subspecialties including a laboratory conducting tests only for newborns, and Masters-level nursing staff, death rates here have fallen dramatically, from 21% in 1971 to 6.8% in 1985.

The Med is proud of its education and research roles. Not only does it train some 900 medical students and others each year, but it conducts research programs in such areas as the treatment of shock, the use of computerized tomography and angiography in trauma cases, and optimal nutritional studies in newborns.

Fourteen percent of its $87 million budget comes from Medicare, 27% from Medicaid, 19% from commercial insurance and almost 1% from self-payments.

The Med receives an appropriation of about $26.8 million, (almost 30% of its budget) from Shelby County, Tennesse Health Care Corporation, a not-for-profit organization. The MED is managed by the Shelby Corporation. Its average daily occupancy rate is 86%.

MEMPHIS, TUESDAY, JULY 7, 1987

Final hearings slated on hospital transfers

By Stephen G. Tompkins
Staff Reporter

The Tennessee Board for Licensing Health Care Facilities yesterday announced a final series of four public hearings on proposed new rules governing the transfer of patients from one hospital to another.

The regulations would prohibit a hospital from transferring patients just because they are poor or uninsured, a practice commonly referred to as "patient-dumping."

It would require hospitals to get a patient's written consent and to medically stabilize the patient before a transfer is made.

The board has tentatively scheduled a vote on the new regulations at its Sept. 9-10 meeting in Nashville.

The public hearings will be held Aug. 11 in Memphis in Room 1206 of the State Office Building; Aug. 13 in Knoxville in Room 235 of the University of Tennessee Student Center; Aug. 14 in Chattanooga in the auditorium of the State Office Building on McCallie Avenue; and Aug. 18 in Nashville in the licensing board's hearing room at 287 Plus Park Boulevard. All hearings will be held from 9 a.m. until noon.

The board has been debating the issue of patient-dumping for almost a year.

Last November, the board adopted new rules that said patients hospitalized for at least 24 hours could no longer be transferred from one hospital to another solely because they could not pay their bills, but excluded emergency room patients from the regulations.

This prompted an angry response from state Sen. John Ford of Memphis, chairman of the Senate Welfare, Health and Human Services Committee who guided through the General Assembly a bill directing the licensing board to adopt rules prohibiting patient-dumping.

Also protesting the new rules were executives at the Regional Medical Center at Memphis, a public hospital which treats more poor and uninsured patients than any other hospital in Tennessee.

Licensing Board chairman Dr. Peggy A. Alsup called for a rehearing on the new rules, and in January the board by a 12-0 vote reversed its earlier decision and tentatively decided to include emergency room patients in the new rules.

If adopted, the new rules would:

- Require hospitals to give every patient arriving at the emergency room or outpatient clinics an "appropriate medical screening examination."
- Allow a patient to be transferred if the receiving hospital has space and agrees to accept the patient, and if the patient or legal guardian also agrees to the transfer.
- Prohibit the transfer if the patient or family does not consent; if the transfer is made "for purely economic reasons, unless (it) is medically appropriate; or if the patient or family was given inadequate or misleading information about the medical necessity of the transfer, the availability of appropriate medical services at the receiving hospital, and the ability of the receiving hospital to provide care to the poor and uninsured.

DUMPING COMPLAINT INVESTIGATIONS STATUS AS OF OCTOBER 9, 1987

- 61 allegations have been received
  - 3 surveys in progress
  - 58 surveys completed
- of the 58 surveys completed
  - 36 in compliance
  - 18 out of compliance
  - 4 survey findings under review

All findings of noncompliance require:

- submission of corrective action plans
- resurveys finding correction, and
- monitoring for long term compliance.

If hospitals found out of compliance fail to meet any of the above requirements, termination will occur as scheduled.

LOG OF SECTION 1867 CASES

Date Complaint Received	Name of Hospital Alleged Noncompliant	Section of COBRA	Survey Completed	In Compliance	Out of Compliance	Termination Scheduled for	Not Terminated Because
09/18/86	San Saba San Saba, TX	Treatment, transfer	09/18/86	10/10/86		11/07/86	Resurvey 10/16/86 found compliance
11/21/86	HCA Valley Brownsville, TX	Treatment, transfer	02/19/87	04/02/87			
12/04/86	Jennie Stuart Hopkinsville, KY	Treatment, transfer	12/24/86	04/04/87			
12/30/86	Lewisville Medical Lewisville, TX	Treatment	03/06/87	07/02/87			
12/19/86	Dermot-Chicot Dermot, AR	Screening, treatment transfer	12/31/86	02/26/87			Resurvey 05/23/87 found compliance
01/05/87	Humana Clear Lake, TX	Treatment, transfer	02/06/87			03/02/87	Resurvey 05/27/87 found compliance
01/08/87	Marymount London, KY	Treatment	01/21/87	02/30/87			
01/16/87	Mary Washington Fredericksburg, VA	Treatment, transfer	08/03/87 investigation in progress				
01/27/87	George County/Mobile Lucedale, MS	Treatment, transfer	02/17/87	03/04/87			
02/17/87	DeTar, Victoria, TX	Treatment, transfer	06/12/87		06/12/87	07/03/87	Resurvey 06/30/87 found compliance
02/20/87	Alvin Community Alvin, TX	Treatment, transfer	07/28/87	08/18/87			
02/24/87	Goodlark Dickson, TN	Treatment	03/03/87	04/01/87			
03/02/87	Westlake Westlake, CA	Treatment	06/30/87	08/13/87			
03/13/87	Methodist Evangelical Louisville, KY	Treatment, transfer	05/14/87	06/23/87			

Date Complaint Received	Name of Hospital Alleged Noncompliant	Section of COBRA	Survey Completed	In Compliance	Out of Compliance	Termination Scheduled for	Not Terminated Because
03/18/87	Brookside San Pablo, CA	Treatment, transfer	03/26/87	03/27/87		04/13/87	Resurvey 04/08/87 found compliance
03/19/87	General Iraan, TX	Treatment	04/08/87	05/15/87			
04/01/87	Colonial Terrell, TX	Treatment, transfer	06/23/87		07/08/87	07/28/87	Resurvey 7/27/87 found compliance

LOG OF SECTION 1867 CASES

Date Complaint Received	Name of Hospital Alleged Noncompliant	Section of COBRA	Survey Completed	In Compliance	Out Compliance	Termination Scheduled for	Not Terminated Because
04/01/87	Wilson N. Jones Sherman, TX	Screening, treatment, transfer	06/22/87	07/01/87			
04/08/87	Jackson-Madison Jackson, TN	Treatment	04/22/87	05/08/87			
04/08/87	South Plains Amherst, TX	Treatment, transfer	06/09/87		06/19/87	07/10/87	Resurvey 07/08/87 found compliance
04/08/87	Winter Garden Memorial, Dilly, TX	Treatment, transfer	04/28/87	06/04/87			
04/09/87	Los Medanos Pittsburg, CA	Transfer	04/17/87		04/27/87 deemed status removed - PRO investigated		08/07/87 deemed status returned - in compliance
04/15/87	Trinity Memorial Trinity, TX	Treatment, transfer	05/22/87	06/30/87			
04/17/87	Brownsville Medical Brownsville, TX	Treatment, transfer	04/22/87	07/20/87			
04/27/87	Methodist Somerville, TN	Treatment, transfer	05/08/87	07/13/87			
04/30/87	Mizelle Opp, AL	Treatment, transfer	05/12/87		07/28/87	08/15/87	Resurvey 8/10/87 found compliance
05/05/87	Fannin County Bonham, TX	Treatment, transfer	06/26/87	07/21/87			
05/05/87	Lillian Hudspeth Sonora, TX	Treatment, transfer	05/20/87	05/20/87			
05/05/87	Charter Community Cleveland, TX	Treatment, transfer	05/06/87		05/20/87	06/05/87	Resurvey 05/26/87 found compliance
05/06/87	Methodist Memphis, TN	Treatment	05/08/87	06/10/87			

LOG OF SECTION 1867 CASES

Date Complaint Received	Name of Hospital Alleged Noncompliant	Section of COBRA	Survey Completed	In Compliance	Out Compliance	Termination Scheduled for	Not Terminated Because
05/12/87	Terrell Community Terrell, TX	Treatment, transfer	08/19/87	09/23/87			
05/12/87	Mitchell County Colorado City, TX	Treatment, transfer	08/07/87	08/26/87			
05/12/87	HCA South Arlington Medical Center Arlington, TX	Treatment, transfer	07/30/87	09/29/87			
05/12/87	Riverside Corpus Christi, TX	Treatment, transfer					Violation occurred prior to effective date of Section 1867
05/19/87	Methodist Jonesboro, AR	Treatment, transfer	06/04/87	06/12/87			
05/27/87	Oakgrove Louisiana West Carroll Parish,LA	Treatment, transfer	Not yet done				
05/27/87	Central Texas Med. Ctr. Hearne, TX	Treatment, transfer	05/27/87		06/19/87	07/10/87	Resurvey 7/08/87 found compliance
06/10/87	Trinity Memorial Trinity, TX	Transfer	06/30/87		07/20/87		Violation occurred prior to effective date of Sec. 1867.
06/11/87	Metropolitan Dallas, TX	Screening	07/01/87		07/01/87	08/01/87	Resurvey 7/30/87 found compliance
06/15/87	Baptist Memorial Memphis, TN	Treatment	06/29/87	08/04/87			
06/26/87	Westlake Cumberland Columbia, KY	Treatment	06/26/87	07/20/87			
06/15/87	Central Medical Ctr. St. Louis, MO	Transfer	06/18/87		06/18/87		Resurvey 06/24/87 found compliance
06/29/87	Methodist Dyersburg, TN	Treatment	07/01/87	08/04/87			

LOG OF SECTION 1867 CASES

Date Complaint Received	Name of Hospital Alleged Noncompliant	Section of COBRA	Survey Completed	In Compliance	Out Compliance	Termination Scheduled for	Not Terminated Because
07/02/87	Arundel Glen Burnie, MD	Treatment, transfer	07/08/87	08/19/87			
07/10/87	University of Chicago Chicago, IL	Treatment, transfer	07/16/87		07/20/87	08/08/87	Resurvey 07/23/87 found compliance
07/29/87	Sherman Oaks Canoga, CA	Screening	08/11/87	10/09/87			
07/29/87	Daniel Freeman Mem. Inglewood, CA	Transfer	08/05/87	08/21/87			
07/30/87	Martin Luther King, Jr. General Los Angeles, CA	Screening, treatment transfer	08/27/87	09/22/87			
07/30/87	LA County Harbor/ UCLA Med Ctr. Torrance, CA	Screening, treatment transfer	08/25/87	09/22/87			
08/14/87	White Memorial Med Ctr Los Angeles, CA	Transfer	09/09/87	in progress			
08/14/87	Medical Ctr. Tarzana Tarzana, CA	Transfer	09/10/87	in progress			
08/14/87	Centinella Hospital Inglewood, CA	Transfer	09/01/87	10/01/87			
08/14/87	Community Bolivar, TN	Screeening, treatment transfer	08/28/87		09/22/871	10/15/87	Resurvey 10/06/87 found compliance
08/20/87	Memorial Med Ctr Corpus Christi, TX	Examination	08/20/87	09/20/87			
08/21/87	Lake Livingston Med Ctr Livingston, TX	Transfer	08/21/87	09/04/87	09/25/87		Resurvey 9/23/87 found compliance
08/27/87	St. Elizabeth Baker, OR	Treatment	08/28/87	09/17/87			

LOG OF SECTION 1867 CASES

Date Complaint Received	Name of Hospital Alleged Noncompliant	Section of COBRA	Survey Completed	In Compliance	Out Compliance	Termination Scheduled for	Not Terminated Because
09/04/87	University General Seminole, FL	Screening, treatment	09/23/87	10/05/87			
09/09/87	West Orange Mem. Winter Garden, FL	Screening, treatment transfer	10/07/87				
09/10/87	South Fulton Eastpoint, GA	Treatment, transfer	09/11/87		09/15/87	10/06/87	Resurvey 10/02/87 found compliance
09/11/87	Methodist South CA Arcadia, CA	Treatment, transfer	*not yet surveyed due to SA workload and earthquake.				
09/11/87	San Dimas San Dimas, CA	Treatment, transfer					
TOTAL	61 allegations						

cc: Dr Brown
Dr Kellermann

JCAH PERSPECTIVES

July/August 1987
Volume 7
Number 7/8

In This Issue

Standards

- Organizations must document compliance with Joint Commission standards that concern emergency patient transfers, page 1.
- **Implementation monitoring status of some standards will be terminated in December; standards designated for implementation monitoring will be reviewed every June for possible changes in status, page 5.**

Accreditation

- Hospitals should not wait for the Agenda for Change initiatives to be implemented before they expand their quality assurance activities. Dr O'Leary comments on this in the "President's Column," page 2.
- Hospital Accreditation Program accreditation reports now link recommendations directly to the standards and required characteristics of the *Accreditation Manual for Hospitals* (*AMH*), page 10.
- Health care organizations are encouraged to report to the Food and Drug Administration all incidents that indicate defects in medical equipment design, page 5.

Worth Repeating

- The Joint Commission reemphasizes its positions on the use of preprinted medical records and on delinquent medical records, page 7.

Publications

- The 1988 edition of the *AMH* and a number of important educational publications are available, page 9.
- Proceedings of an international symposium on quality assurance are available, page 10.

Documentation of Compliance with 'Emergency Services' Standards

Effective immediately, organizations will be expected to document their compliance with Joint Commission standards that concern transfer of emergency patients from one hospital to another. The Joint Commission has intensified this aspect of its survey of hospital emergency services because of an increasing number of complaints of inappropriate patient transfers.

Although the *Accreditation Manual for Hospitals* (*AMH*) does not specifically refer to documentation requirements, compliance with Joint Commission standards regarding transfer of emergency patients can adequately be assessed only through a hospital's written records. For this reason, Joint Commission surveyors have been issued guidelines that define compliance with the transfer procedure standards to include thorough documentation of the process. Hospitals must also document the quality assurance methods they use to evaluate patient transfers.

The relevant standards are found in the "Emergency Services" chapter of the *AMH.* The content of a hospital's written transfer protocol is described in Required Characteristics ER.1.6 through ER.1.6.2.2. The new surveyor guidelines define full compliance with these required characteristics, and with the provision for quality control in Required Characteristic ER.8.1.5, as follows:

- **Document initial emergency care to stabilize the patient prior to the transfer.** *(ER.1.6.1: A hospital is capable of instituting essential*

(continued on page 3)

President's Column

"We're waiting to see what the Joint Commission does." I continue to hear this disquieting refrain from a number of hospitals as they gingerly approach their expanding quality assurance responsibilities. Deference couched in caution is occasionally a sound approach, but not in an environment where quality of care evaluation has become everybody's business. Given the realities facing hospitals and physicians today, waiting for anybody is tantamount to a strong death wish.

The Joint Commission's Agenda for Change initiatives are now well under way. The Department of Research and Development has recruited a cadre of outstanding individuals; the Project Steering Committee is fully operational; and the first four task forces, supported by funding from the Robert Wood Johnson Foundation, have been appointed and are meeting. The task forces will produce the first sets of clinical and organizational indicators by late summer, and field testing in selected pilot hospitals will commence shortly thereafter.

Thus, the Joint Commission is moving, but hospitals should also be moving. Neither the current nor the future quality assurance standards are shrouded in mystery. These standards, which constitute the basic framework for the Agenda for Change initiatives, continue to provide a commonsense approach to problem identification and problem resolution. Yet today, only a handful of hospitals are in full compliance with the requirements of the quality assurance standards.

The quality assurance standards are not the wild concoction of a sadistic bureaucrat. Perhaps hospitals should forget for the moment that there is a Joint Commission and instead make an honest assessment of the real world. Hospital mortality figures are already in the public domain. These figures and other measures of clinical outcome will increasingly be available to interested parties, including purchasers of care and the media. These figures do not represent measures of quality, but they will be widely construed as such. And hospital reputations and patient volumes will rise and fall on the basis of this numerical morass.

The big question for the individual hospital is how well prepared it is to defend itself. Will it be able to counter or explain misleading data or possibly accurate data that suggests substandard care? Simple logic dictates that the hospital's ability to respond depends on whether or not it has an effective quality assurance system—a system that assures ongoing monitoring and evaluation of important aspects of patient care, identification of significant problems, and timely resolution of those problems. Such a system significantly increases the likelihood that the hospital would know of its problems before the government or the media did and that it would have actually addressed the problems rather than only have been able to explain them.

The point I wish to make is that quality assurance today is a self-interest issue for hospitals. We care a great deal that hospitals be in compliance with Joint Commission standards; however, our interest lies not in a paper exercise but rather in assisting hospitals to provide high-quality care. Hospitals should be *in charge* of their quality of care issues.

Standards compliance requirements are going to get tougher. At its July 1986 meeting, the Accreditation Committee removed from implementation monitoring status a series of monitoring and

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President's Column (continued)

evaluation standards that cut a wide swath across medical staff, nursing, and ancillary service responsibilities. This was a difficult decision because Joint Commission monitoring had revealed little evidence of progress in the field. But instructional materials and educational seminars addressing the monitoring and evaluation functions are now widely available. Thus, compliance is achievable, and compliance in this critical area is something to be devoutly desired by hospitals.

Not removed from implementation monitoring status were related standards that require the use of quality assurance findings in the periodic recredentialing process. Here too, progress in the field has been negligible, but instructional materials to support hospitals are still being developed. Nevertheless, compliance with these standards will also eventually be required, probably early in 1989.

The progressive enforcement of existing quality assurance standards requirements has more to do with effective implementation of the Agenda for Change initiatives than any specific aspect of the project. The project tasks are designed to increase the clinical emphasis of the accreditation process, to sharpen the focus on important quality-related activities in the organization, and to stress the importance of performance outcomes, both organizational and clinical. The content of the final product is not known, and therein may lie the hesitancy that is afoot in the field.

In broad perspective, however, the Agenda for Change initiatives are intended to lead to significant *refinements* in the evaluation of organizations and their efforts in providing high-quality care. The goal is to develop an improved method of evaluation. But a method is only a method. And it will have little meaning or impact in an unreceptive hospital environment.

Creating the right environment for quality assurance activities is the hospital's responsibility. And many hospitals have a great deal of work to do before that objective is met. Adequate resources must be committed; up to 1% of the expenditure budget is a good starting point. Internal systems to assure collection, coordination, and reporting of information must be established. A quality assurance information system must be developed or acquired so that the hospital can become facile in interpreting and managing clinical data. Managerial competency at the departmental level must be assured. And finally, there must be an aggressive team-building effort among management, the governing body, and the medical staff.

Once these tasks have been completed, then it will be time to focus on the nuances of the Agenda for Change initiatives. In an ideal world, the implementation of these initiatives in 1990 should be a remarkable non-event. For by 1990, at the level of the individual hospital, the battle may have already been won or lost. Nonhospital organizations should also heed these admonitions, for the same environmental pressures are no more than one step removed from them as well.

The time for movement is now.

Dennis S. O'Leary, MD
President

Documentation of Compliance (continued)

lifesaving measures and implementing emergency procedures that will minimize further compromise of the condition of any infant, child, or adult being transported.) **Surveyor Guideline:** The medical record should contain documentation of the basis for determining stabilization of patients before transfer. This documentation must include

- — a chronology of events that have taken place in the case
- — measures taken or treatment implemented
- — a description of the patient's response to treatment, and
- — the results of measures that have been taken to prevent further deterioration.

(continued on page 4)

Documentation of Compliance (continued)

- **Prohibit arbitrary transfers.** *(ER 1.6.2: Unless extenuating circumstances are documented in the patient's record, no patient is arbitrarily transferred to another hospital if the hospital where he is initially seen has the means for providing adequate care.)* **Surveyor Guideline:** The hospital's transfer policy should state that no patient is transferred arbitrarily from the hospital to another facility before completion of emergency treatment if emergency patient care can be provided adequately at the original hospital. Documentation in a sample of emergency patient records should indicate that patients have not been transferred, for example, on the basis of

— ability to pay or method of payment
— the amount of time required for emergency treatment
— prognosis (eg, as critical or terminal)
— immigration status
— sex, race, creed, or national origin; or
— criminal status.

- **Document the consent of the receiving facility to accept the patient.** *(ER.1.6.2.1: The patient is not transferred until the receiving facility has consented to accept the patient and the patient is considered sufficiently stabilized for transport.)* **Surveyor Guideline:** The transfer of a patient may be initiated before, but not carried out until after, the receiving facility has consented to accept the patient. Acceptance should be documented in the medical record or in a register (ie, log) that identifies

— the patient
— the receiving facility
— the consenting party's name and position or responsibility, and
— the date and time of the acceptance.

The medical record or register should include documentation of

— the information given to the receiving facility
— the suspected diagnoses
— the patient's stabilized condition, and
— the name of the informant at the hospital that originally received the patient.

If the receiving hospital is given medical information about the patient by someone other than the person who has requested the receiving hospital to accept the patient, both persons' names should be documented. There should also be a written record of the medical information that was transmitted, and information describing responsibility for the patient during transfer and transport to the receiving facility.

- **Send medical information with the patient.** *(ER.1.6.2.2: Responsibility for the patient during transfer is established, and all pertinent medical information accompanies the patient being transferred.)* **Surveyor Guideline:** At the time a patient is transported to another facility, a legible, current medical record (or a copy of it) accompanies the patient.

It is acceptable to send a summary of

— all pertinent events
— actions
— diagnoses, and
— treatment.

The summary should include a written record of

— the authorization of the transfer
— the receiving hospital's acceptance of the transfer, and
— the names of all personnel who were involved in the transfer.

- **Document quality control of patient transfers.** *(ER.8.1: At least the following quality control mechanisms are established: . . . ER.8.1.5: Patient transfer is carried out safely and in accordance with a written transfer protocol.)* **Surveyor Guideline:** The hospital documents the ongoing, systematic surveillance and review of emergency transfers. The hospital performs this evaluation in order to determine compliance with the transfer policy established in accordance with ER.1.6 through ER.1.6.2.2. The evaluation includes the review of the register, roster, medical records, and other documents, as appropriate for verifying at least

— the name of the patient transferred
— the stabilization of the patient prior to transfer
— the record of acceptance from the receiving hospital and the name of the person responsible for accepting the patient
— a record of the information sent with the patient (eg, a copy of the emergency service record), and

umentation of Compliance (continued)

ıy unusual events that occurred dur-
ıg the transfer.
ıuestions about patient transfers
ı be addressed to Hugh Buff, MD,

Associate Director of the Hospital Accreditation Program, at the corporate office of the Joint Commission on Accreditation of Hospitals.

plementation Monitoring Policy ıanges

ning in 1988, all standards that have
designated for implementation moni-
will be reviewed every June by the
Commission's Accreditation Commit-
he Committee will identify those stan-
to be removed from implementation
oring status, and these actions will
ıe effective the following December

he new policy was developed to
careful coordination and scrutiny of
ards in implementation monitoring
. The decision to approve the new
was made at the July meeting of the
ditation Committee.
tandards that are under implemen-
monitoring are surveyed and are
t to recommendations in the accred-
report but the findings do not affect
creditation decision. The Joint Com-
n initiated the implementation moni-
system in 1985 to provide organi-
s appropriate time to adjust to new
ards with which they might have
lty attaining substantial compliance
liately.
t its July meeting, the Accreditation
iittee determined that certain stan-
now under implementation monitor-
ill be cleared of that status on
nber 31, 1987. These standards are
in the *Accreditation Manual for Hos-*
(AMH) concerning the use of peer
mendations in privilege delineation
ose in the *AMH* and other standards
ıls that concern monitoring and

evaluation of the quality and appropriateness of care.

The revised drug usage evaluation standards that were added to the "Medical Staff" chapter of the *AMH* (in its 1986 edition) and standards requiring the use of quality assurance findings in the periodic reappointment process will be reviewed in June 1988 for possible termination of implementation monitoring status. Similarly, standards on the use of quality assurance findings in competence assessment of health care personnel (*Ambulatory Health Care Standards Manual*), the recently approved community mental health standards (*Consolidated Standards Manual*), and the general revisions in the hospice standards (*Hospice Standards Manual*) will also be reviewed at that time.

The annual review of standards in implementation monitoring status will be based on

- Progress the field has made in implementing the standards. This will be evaluated on the basis of the number of surveyed organizations failing to demonstrate substantial compliance with the standards in question.
- The availability of educational materials and programs to assist the field in implementing the standards.

Questions about implementation monitoring should be addressed to James W. Dilley, Director of the Department of Survey Validation, at the Joint Commission corporate office.

port Device Failures to the FDA

Accreditation

care organizations are encouraged
careful attention to the Food and
Administration's (FDA) system for
ıng the performance of medical de-
ınd to report to the FDA all incidents
dicate defects in medical equipment

design. Further, organizations that are considering purchase of a new device should contact the FDA to seek information about any problems with the device that other users have reported.

(continued on page 6)

Assembly Bill No. 214

CHAPTER 1225

An act to amend Sections 1317, 1798, 1798.170, 1798.172, 1798.206, and 1798.208 of, and to add Sections 1317.1, 1317.2, 1317.2a, 1317.3, 1317.4, 1317.5, 1317.6, 1317.7, 1317.8, 1317.9, 1317.9a, and 1798.205 to, the Health and Safety Code, relating to hospital emergency medical treatment and patient transfer.

[Approved by Governor September 27, 1987. Filed with
Secretary of State September 27, 1987.]

LEGISLATIVE COUNSEL'S DIGEST

AB 214, Margolin. Hospital emergency patient transfers.

Various provisions of existing law regulate hospitals and the treatment of patients.

This bill would regulate the treatment of patients brought to hospital emergency rooms and the transfer of those patients to other medical facilities. It would prohibit basing an emergency patient's treatment on the patient's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, unless the circumstances are medically significant to the provision of appropriate medical care to that individual. The bill would revise the definition of "emergency services and care" and "medical hazard" and define "consultation" and "within the capability of the facility." It would specify conditions under which emergency medical patients may be transferred and procedures which may be followed.

The bill would specify under what conditions a hospital is obligated to accept the transfer of a patient, and would require a hospital that is unable to accept the transfer of a patient for whom it is legally or contractually liable, to make arrangements for the patient's care. The bill would require receiving hospitals which do not accept transfers of, or make other appropriate arrangements for, certain medically stable patients for which they are contractually or statutorily obligated to provide care, to be liable, as specified.

The bill would require hospitals to adopt policies and transfer protocols consistent with the bill and a hospital's compliance with specified procedures would be a condition of licensure or revocation thereof. Violators could also be fined, as specified, for hospital violations, and taking into account certain factors or have their emergency medical service permits revoked. This bill would also create certain civil actions, as specified, and exempt the health facility and specified health professionals from liability for refusing to render emergency services under certain circumstances. The receiving hospital, and physicians, emergency room health personnel at the receiving hospital, and certified prehospital emergency personnel would be required to report all apparent violations known to them to the State Department of Health Services for investigation. The bill would provide that a physician shall not be prevented from exercising professional judgment in conflict with certain state and local regulations under specified circumstances.

Local emergency medical services agencies would also be obligated to mandate transfer protocols, guidelines, and agreements, as specified. These requirements would impose a state-mandated local program on these agencies.

This bill would create new misdemeanors, thus imposing new duties upon local law enforcement agencies, thereby constituting a state-mandated local program.

This bill would also provide that the Governor shall request the federal government to credit certain monetary penalties against subsequent penalties assessed by the federal government and require the department to take certain actions to ensure that a specified cumulative maximum limit of fines assessed under state and federal law is not exceeded.

Under existing law, the medical direction and management of an emergency medical services system on the local level is under the control of the medical director of the local emergency medical services agency.

This bill would establish procedures for the medical director of a base station who questions the medical effect of a policy of a local emergency medical services agency to have a hearing on the matter.

This hearing procedure would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates which do not exceed $500,000 statewide and other procedures for claims whose statewide costs exceed $500,000.

This bill would provide that for certain costs no reimbursement is required by this act for a specified reason.

Moreover, the bill would provide that no reimbursement shall be made from the State Mandates Claims Fund for other costs mandated by the state pursuant to this act, but would recognize that local agencies and school districts may pursue any available remedies to seek reimbursement for those other costs.

The people of the State of California do enact as follows:

SECTION 1. Section 1317 of the Health and Safety Code is amended to read:

1317. (a) Emergency services and care shall be provided to any person requesting services or care, or for whom services or care is requested, for any condition in which the person is in danger of loss of life, or serious injury or illness, at any health facility licensed under this chapter that maintains and operates an emergency department to provide emergency services to the public when the health facility has appropriate facilities and qualified personnel available to provide the services or care.

(b) In no event shall the provision of emergency services and care be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to that individual.

(c) Neither the health facility, its employees, nor any physician, dentist, or podiatrist shall be held liable in any action arising out of a refusal to render emergency services or care if reasonable care is exercised in determining and treating the condition of the person, or in determining the appropriateness of the facilities, the qualifications and availability of personnel to render the services.

(d) Emergency services and care shall be rendered without first questioning the patient or any other person as to his ability to pay therefor. However, the patient or his legally responsible relative or guardian shall execute an agreement to pay therefor or otherwise supply insurance or credit information promptly after the services are rendered.

(e) If a health facility subject to this chapter does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency exists and shall direct the persons seeking emergency care to a nearby facility which can render the needed services, and shall assist the persons seeking emergency care in obtaining the services, including transportation services, in every way reasonable under the circumstances.

(f) No act or omission of any rescue team established by any health facility licensed under this chapter, or operated by the federal or state government, a county, or by the Regents of the University of California, done or omitted while attempting to resuscitate any person who is in immediate danger of loss of life shall impose any liability upon the health facility, the officers, members of the staff, nurses, or employees of the health facility, including, but not limited to, the members of the rescue team, or upon the federal or state government or a county, if good faith is exercised.

(g) "Rescue team," as used in this section, means a special group of physicians and surgeons, nurses, and employees of a health facility who have been trained in cardiopulmonary resuscitation and have been designated by the health facility to attempt, in cases of emergency, to resuscitate persons who are in immediate danger of loss of life.

(h) This section shall not relieve a health facility of any duty otherwise imposed by law upon the health facility for the designation and training of members of a rescue team or for the provision or maintenance of equipment to be used by a rescue team.

SEC. 2. Section 1317.1 is added to the Health and Safety Code, to read:

1317.1. Unless the context otherwise requires, the following definitions shall control the construction of this article:

(a) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

(b) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Placing the patient's health in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

(c) "Active labor" means a labor at a time at which either of the following would occur:

(1) There is inadequate time to effect safe transfer to another hospital prior to delivery.

(2) A transfer may pose a threat to the health and safety of the patient or the unborn child.

(d) "Hospital" means all hospitals with an emergency department licensed by the state department.

(e) "State department" means the State Department of Health Services.

(f) "Medical hazard" means a material deterioration in medical condition in, or jeopardy to, a patients' medical condition or expected chances for recovery.

(g) "Board" means the Board of Medical Quality Assurance.

(h) "Within the capability of the facility" means those capabilities which the hospital is required to have as a condition of its emergency medical services permit and services specified on Services Inventory Form 7041 filed by the hospital with the Office of Statewide Health Planning and Development.

(i) "Consultation" means the rendering of an opinion, advice, or prescribing treatment by telephone and, when determined to be medically necessary jointly by the emergency and specialty physicians, includes review of the patient's medical record, examination, and treatment of the patient in person by a specialty physician who is qualified to give an opinion or render the necessary treatment in order to stabilize the patient.

SEC. 3. Section 1317.2 is added to the Health and Safety Code, to read:

1317.2. No person needing emergency services and care may be transferred from a hospital to another hospital for any nonmedical reason (such as the person's inability to pay for any emergency service or care) unless each of the following conditions are met:

(a) The person is examined and evaluated by a physician including, if necessary, consultation prior to transfer.

(b) The person has been provided with emergency services and care such that it can be determined, within reasonable medical probability, that the transfer or delay caused by the transfer will not create a medical hazard to the person.

(c) A physician at the transferring hospital has notified and has obtained the consent to the transfer by a physician at the receiving hospital and confirmation by the receiving hospital that the person meets the hospital's admissions criteria relating to appropriate bed, personnel, and equipment necessary to treat the person.

(d) The transferring hospital provides appropriate personnel and equipment which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use to effect the transfer.

(e) All the person's pertinent medical records and copies of all the appropriate diagnostic test results which are reasonably available are transferred with the person.

(f) The records transferred with the person include a "Transfer Summary" signed by the transferring physician which contains relevant transfer information. The form of the "Transfer Summary" shall, at a minimum, contain the person's name, address, sex, race, age, insurance status, and medical condition; the name and address of the transferring doctor or emergency room personnel authorizing the transfer; the time and date the person was first presented at the transferring hospital; the name of the physician at the receiving hospital consenting to the transfer and the time and date of the consent; the time and date of the transfer; the reason for the transfer; and the declaration of the transferring physician that the transferring physician is assured, within reasonable medical probability, that the transfer creates no medical hazard to the patient. Neither the transferring physician nor transferring hospital shall be required to duplicate, in the "Transfer Summary," information contained in medical records transferred with the person.

(g) The transfer conforms with regulations established by the state department. These regulations may prescribe minimum protocols for patient transfers.

(h) Nothing in this section shall apply to a transfer of a patient for medical reasons.

(i) Nothing in this section shall prohibit the transfer or discharge of a patient when the patient or the patient's representative requests a transfer or discharge and gives informed consent to the transfer or discharge against medical advice.

SEC. 4. Section 1317.2a is added to the Health and Safety Code, to read:

1317.2a. (a) A hospital which has a legal obligation, whether imposed by statute or by contract to the extent of that contractual obligation, to any third-party payer, including, but not limited to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, or preferred provider organization, a county, or an employer to provide care for a patient under the circumstances specified in Section 1317.2 shall receive that patient to the extent required by the applicable statute or by the terms of the contract, or, when the hospital is unable to accept a patient for whom it has a legal obligation to provide care whose transfer will not create a medical hazard as specified in Section 1317.2, it shall make appropriate arrangements for the patient's care.

(b) A county hospital shall accept a patient whose transfer will not create a medical hazard as specified in subdivision (b) of Section 1317.2 and who is determined by the county to be eligible to receive health care services required under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code, unless the hospital does not have appropriate bed capacity, medical personnel, or equipment required to provide care to the patient in accordance with accepted medical practice. When a county hospital is unable for any of these reasons to accept a patient whose transfer will not create a medical hazard as specified in subdivision (b) of Section 1317.2, it shall make appropriate arrangements for the patient's care. The obligation to make appropriate arrangements does not mandate a level of service or payment, does not modify the county's obligations under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code, and does not create a cause of action or limit a county's flexibility to manage county health systems within available resources, but this flexibility shall not diminish a county's responsibilities under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code or the requirements contained in Chapter 2.5 (commencing with Section 1440).

(c) When a patient is transferred pursuant to subdivision (a), the receiving hospital shall provide personnel and equipment reasonably required in the exercise of good medical practice for the care of the transferred patient.

(d) Any third-party payer, including, but not limited to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, preferred provider organization, or employer which has a statutory or contractual obligation to provide or indemnify emergency medical services on behalf of a patient shall be liable, to the extent of the contractual obligation, for the reasonable charges of the transferring hospital and the treating physicians for the emergency services provided pursuant to this article, except that the patient shall be responsible for any deductible or copayment obligation. Notwithstanding this section, the liability of a third-party payer which has contracted with health care providers for the provision of these emergency services shall be set by the terms of that contract. Notwithstanding this section, the liability of a third-party payer that is licensed by the Insurance Commissioner or the Commissioner of Corporations and has a contractual obligation to provide or indemnify emergency medical services shall be determined in accordance with the terms of that contract and shall remain under the sole jurisdiction of that licensing agency.

(e) A hospital which has a legal obligation to provide care for a patient as specified by subdivision (a) of Section 1317.2a, to the extent of its legal obligation, imposed by statute or by contract to the extent of that contractual obligation and which does not accept transfer of, or make other appropriate arrangements for, medically stable patients in violation of this article or regulations adopted pursuant thereto shall be liable for the reasonable charges of the transferring hospital and treating physician for providing services and care which should have been provided by the receiving hospital.

(f) Subdivisions (d) and (e) do not apply to county obligations under Section 17000 of the Welfare and Institutions Code.

(g) Nothing in this section shall be interpreted to require a hospital to make arrangements for the care of a patient for whom the hospital does not have a legal obligation to provide care.

SEC. 5. Section 1317.3 is added to the Health and Safety Code, to read:

1317.3. (a) As a condition of licensure, each hospital shall adopt, in consultation with the medical staff, policies and transfer protocols consistent with this article and regulations adopted hereunder.

(b) As a condition of licensure, each hospital shall adopt a policy prohibiting discrimination in the provision of emergency services and care based on race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to that individual.

(c) As a condition of licensure, each hospital shall require that, as a condition of staff privileges, physicians who serve on an "oncall" basis to the hospital's emergency room cannot refuse to respond to a call on the basis of the patient's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to that individual. If a contract between a physician and hospital for the provision of emergency room coverage presently prevents the hospital from imposing those conditions, the conditions shall be included in the contract as soon as is legally permissible. Nothing in this section shall be construed as requiring that any physician serve on an "oncall" basis.

(d) As a condition of licensure, all hospitals will inform all persons presented to an emergency room or their representatives if any are present and the person is unable to understand verbal or written communication, both orally and in writing, of the reasons for the transfer or refusal to provide emergency services and care and of the person's right to emergency services and care prior to transfer or discharge without regard to ability to pay. Nothing in this subdivision requires notification of the reasons for the transfer in advance of the transfer where a person is unaccompanied and the hospital has made a reasonable effort to locate a representative, and because of the person's physical or mental condition, notification is not possible. All hospitals shall prominently post a sign in their emergency rooms informing the public of their rights. Both the posted sign and written communication concerning the transfer or refusal to provide emergency services and care shall give the address of the state department as the government agency to contact in the event the person wishes to complain about the hospital's conduct.

(e) If a hospital does not timely adopt the policies and protocols required in this article, the hospital, in addition to denial or revocation of any of its licenses, shall be subject to a fine not to exceed one thousand dollars ($1,000) each day after expiration of 60 days' written notice from the state department that the hospital's policies or protocols required by this article are inadequate unless the delay is excused by the state department upon a showing of good and sufficient cause by the hospital. The notice shall include a detailed statement of the state department's reasons for its determination and suggested changes to the hospital's protocols which would be acceptable to the state department.

(f) Each hospital's policies and protocols required in or under this article shall be submitted for approval to the state department within 90 days of the state department's adoption of regulations under this article.

SEC. 6. Section 1317.4 is added to the Health and Safety Code, to read:

1317.4. (a) All hospitals shall maintain records of each transfer made or received, including the "Memorandum of Transfer" described in subdivision (g) of Section 1317.2, for a period of three years.

(b) All hospitals making or receiving transfers shall file with the state department annual reports on forms prescribed by the state department which shall describe the aggregate number of transfers made and received according to the person's insurance status and reasons for transfers.

(c) The receiving hospital, and all physicians, other licensed emergency room health personnel at the receiving hospital, and certified prehospital emergency personnel who know of apparent violations of this article or the regulations adopted hereunder shall, and the corresponding personnel at the transferring hospital and the transferring hospital may, report the apparent violations to the state department on a form prescribed by the state department within one week following its occurrence. The state department shall promptly send a copy of the form to the hospital administrator and appropriate medical staff committee of the transferring hospital and the local emergency medical services agency unless the state department concludes that the complaint does not allege facts requiring further investigation, or is otherwise unmeritorious, or the state department concludes, based upon the circumstance of the case, that its investigation of the allegations would be impeded by disclosure of the form. When two or more persons required to report jointly have knowledge of an apparent violation, a single report may be made by a member of the team selected by mutual agreement in accordance with hospital protocols. Any individual, required to report by this section, who disagrees with the proposed joint report has a right and duty to separately report. A failure to report shall not subject the individual or institution to the penalties set forth in Section 1317.6.

(d) No hospital, government agency, or person shall retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to a physician or other personnel for reporting in good faith an apparent violation of this article or the regulations adopted hereunder to the state department, hospital, medical staff, or any other interested party or government agency.

(e) No hospital, government agency, or person shall retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to a physician who refused to transfer a patient when the physician determines, within reasonable medical probability, that the transfer, or delay caused by the transfer, will create a medical hazard to the person.

(f) Any person who violates subdivision (d) or (e) is subject to a civil money penalty of no more than ten thousand dollars ($10,000). The remedy specified in this section shall be in addition to any other remedy provided by law.

(g) The state department shall on an annual basis publish and provide to the Legislature a statistical summary by county on the extent of economic transfers of emergency patients, the frequency of medically hazardous transfers, the insurance status of the patient populations being transferred and all violations finally determined by the state department describing the nature of the violations, hospitals involved, and the action taken by the state department in response. These summaries shall not reveal the identity of individual persons transferred.

(h) Proceedings by the state department to impose a fine under Section 1317.3 or 1317.6, and proceedings by the board to impose a fine under Section 1317.6, shall be conducted as follows:

(1) If a hospital desires to contest a proposed fine, the hospital shall, within 15 business days after service of the notice of proposed fine, notify the director in writing of its intention to contest the proposed fine. If requested by the hospital, the director or the director's designee, shall hold, within 30 business days, an informal conference, at the conclusion of which he or she may affirm, modify, or dismiss the proposed fine. If the director or the director's designee affirms, modifies, or dismisses the proposed fine, he or she shall state with particularity in writing his or her reasons for that action, and shall immediately transmit a copy thereof to the hospital. If the hospital desires to contest a determination, the hospital shall inform the director in writing within 15 business days after it receives the decision by the director or director's designee. The hospital shall not be required to request an informal conference to contest a proposed fine as provided in this section. If the hospital fails to notify the director in writing that it intends to protest the proposed fine within the times specified in this subdivision, the proposed fine shall be deemed a final order of the state department and shall not be subject to further administrative review.

(2) If a hospital notifies the director that it intends to contest a proposed fine, the director shall immediately notify the Attorney General. Upon notification, the Attorney General shall promptly take all appropriate action to enforce the proposed fine in a court of competent jurisdiction for the county in which the hospital is located.

(3) If a judicial proceeding is prosecuted under the provisions of this section, the state department shall have the burden of establishing by a preponderance of the evidence that the alleged facts supporting the proposed fine occurred, that the alleged facts constituted a violation for which a fine may be assessed under Section 1317.3, 1317.4, or 1317.6, and that the proposed fine is appropriate. The state department shall also have the burden of establishing by a preponderance of the evidence that on appeal the assessment of the proposed fine would be upheld. If a hospital timely notifies the state department of its decision to contest a proposed fine, the fine shall not be due and payable unless and until the judicial proceeding is terminated in favor of the state department.

(4) Actions brought under the provisions of this section shall be set for trial at the earliest possible date and shall take precedence on the court calendar over all other cases except matters to which equal or superior precedence is specifically granted by law. Times for responsive pleading and for hearing the proceeding shall be set by

the judge of the court with the object of securing a decision as to subject matters at the earliest possible time.

(5) If the proposed fine is dismissed or reduced, the state department shall take action immediately to ensure that the public records reflect in a prominent manner that the proposed fine was dismissed or reduced.

(6) In lieu of a judicial proceeding, the state department and the hospital may jointly elect to submit the matter to binding arbitration. The parties shall agree upon an arbitrator designated from the American Arbitration Association in accordance with the association's established rules and procedures. The arbitration hearing shall be set within 45 days of the parties' joint election, but in no event less than 28 days from the date of selection of an arbitrator. The arbitrator hearing may be continued up to 15 days if necessary at the arbitrator's discretion. The decision of the arbitrator shall be based upon substantive law and shall be binding on all parties, subject to judicial review. This review shall be limited to whether there was substantial evidence to support the decision of the arbitrator.

(7) Proceedings by the board to impose a fine under Section 1317.6, shall be conducted in accordance with the provisions of Chapter 5 (commencing with Section 11500) of Part 2 of Division 3 of Title 2 of the Government Code.

SEC. 7. Section 1317.5 is added to the Health and Safety Code, to read:

1317.5. (a) All alleged violations of this article and the regulations adopted hereunder shall be investigated by the state department. The state department, with the agreement of the local EMS agency, may refer violations of this article to the local EMS agency for investigation. The investigation shall be conducted pursuant to procedures established by the state department and shall be completed no later than 60 days after the report of apparent violation is received by the state department.

(b) At the conclusion of its investigation, the state department or the local EMS agency shall refer any alleged violation by a physician to a board of medical quality assurance unless it is determined that the complaint is without a reasonable basis.

SEC. 8. Section 1317.6 is added to the Health and Safety Code, to read:

1317.6. (a) Hospitals found by the state department to have committed, or to be responsible for, a violation of the provisions of this article or the regulations adopted hereunder may each be fined by the state department in an amount not to exceed twenty-five thousand dollars ($25,000) for each hospital violation. However, with respect to licensed physicians, the board shall have sole authority to impose a fine. Fines imposed under this section shall not be cumulative.

(1) In determining the amount of the fine for a hospital violation,

the state department shall take into account all of the following:

(A) Whether the violation was knowing or unintentional.

(B) Whether the violation resulted, or was reasonably likely to result, in a medical hazard to the patient.

(C) The frequency or gravity of the violation.

(D) Other civil fines which have been imposed as a result of the violation under Section 1867 of the federal Social Security Act.

It is the intent of the Legislature that the state department has primary responsibility for regulating the conduct of hospital emergency rooms and that fines imposed under this section should not be duplicated by additional fines imposed by the federal government as a result of the conduct which constituted a violation of this section. To effectuate the Legislature's intent, the Governor shall inform the Secretary of the federal Department of Health and Human Services of the enactment of this section and request the federal department to credit any penalty assessed under this section against any subsequent civil monetary penalty assessed pursuant to Section 1867 of the federal Social Security Act for the same violation.

(2) Physicians found by the board to have committed, or to be responsible for, a violation of this article or the regulations adopted pursuant thereto are subject to any and all penalties which the board may lawfully impose and may be fined by the board in an amount not to exceed five thousand dollars ($5,000) for each violation. The board may impose fines when it finds any of the following:

(A) The violation was knowing or willful.

(B) The violation was reasonably likely to result in a medical hazard.

(C) There are repeated violations.

The board shall take into account all of these factors when determining the amount of the fine. Fines imposed under this paragraph shall not duplicate federal fines, and the board shall credit any federal fine against fines imposed under this paragraph.

(3) There shall be a cumulative maximum limit of thirty thousand dollars ($30,000) in fines assessed against either physicians or hospitals under this article and under Section 1867 of the federal Social Security Act for the same circumstances. To effectuate this cumulative maximum limit, the state department shall do both of the following:

(A) As to state fines assessed prior to the final conclusion, including judicial review, if available, of an action against a hospital by the federal Department of Health and Human Services under Section 1867 of the federal Social Security Act, (for the same circumstances finally deemed to have been a violation of this article or the regulations adopted hereunder, because of the state department action authorized by this article), remit and return to the hospital within 30 days after conclusion of the federal action, that portion of the state fine necessary to assure that the cumulative maximum limit is not exceeded.

(B) Immediately credit against state fines assessed after the final conclusion, including judicial review, if available, of an action against a hospital by the federal Department of Health and Human Services under Section 1867 of the federal Social Security Act, which results in a fine against a hospital (for the same circumstances finally deemed to have been a violation of this article or the regulations adopted hereunder, because of the state department action authorized by this article), the amount of the federal fine necessary to assure the cumulative maximum limit is not exceeded.

(b) Any hospital found by the state department pursuant to procedures established by the state department to have committed a violation of this article or the regulations adopted hereunder may have its emergency medical service permit revoked or suspended by the state department.

(c) Any administrative or medical personnel who knowingly and intentionally violates any provision of this article, may be charged by the local district attorney with a misdemeanor.

(d) The penalties listed in subdivisions (a), (b), and (c), shall only be applied for violations of Section 1317, 1317.1, or 1317.2.

(e) Notification of each violation found by the state department of the provisions of this article or the regulations adopted hereunder shall be sent by the state department to the Joint Commission for the Accreditation of Hospitals, and state and local emergency medical services agencies.

(f) Any person who suffers personal harm and any medical facility which suffers a financial loss as a result of a violation of this article or the regulations adopted hereunder may recover, in a civil action against the transferring hospital or responsible administrative or medical personnel, damages, reasonable attorneys' fees, and other appropriate relief. Transferring hospitals from which inappropriate transfers of persons are made in violation of this article and the regulations adopted hereunder shall be liable for the normal charges of the receiving hospital for providing the emergency services and care which should have been provided before transfer. Any person potentially harmed by a violation of this article or the regulations adopted hereunder, or the local district attorney or the Attorney General, may bring a civil action against the responsible hospital or administrative or medical personnel, to enjoin the violation, and if the injunction issues, a court shall award reasonable attorney's fees. The provisions of this subdivision are in addition to other civil remedies and do not limit the availability of the other remedies.

(g) Neither the health facility, its employees, nor any physician, dentist, or podiatrist shall be liable in any action arising out of a refusal to render emergency services or care if the refusal is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition, or that the health facility does not have the appropriate facilities or qualified personnel available to render those services.

SEC. 9. Section 1317.7 is added to the Health and Safety Code, to read:

1317.7. This article shall not preempt any governmental agencies, acting within their authority, from regulating emergency care or patient transfers, including the imposition of more specific duties consistent with the requirements of this article and its implementing regulations. Any inconsistent requirements imposed by the Medi-Cal program shall preempt the provisions of this article with respect to Medi-Cal beneficiaries. To the extent hospitals and physicians enter into contractual relationships with governmental agencies which impose more stringent transfer requirements, those contractual agreements shall control.

SEC. 10. Section 1317.8 is added to the Health and Safety Code, to read:

1317.8. If any provision of this article is declared unlawful or unconstitutional in any judicial action, the remaining provisions of this chapter shall remain in effect.

SEC. 11. Section 1317.9 is added to the Health and Safety Code, to read:

1317.9. The state department shall adopt on an emergency basis regulations to implement the provisions of this article by July 1, 1989.

SEC. 12. Section 1317.9a is added to the Health and Safety Code, to read:

1317.9a. This article shall not be construed as repealing Section 2400 of the Business and Professions Code. Nothing in Sections 1317 to 1317.9a, inclusive, and Section 1798.170 shall prevent a physician from exercising his or her professional judgment in conflict with any state or local regulation promulgated under these sections, so long as the judgment conforms with Sections 1317, 1317.1, and 1317.2, except for subdivision (g) of Section 1317.2, and acting in compliance with the state or local regulations would be contrary to the best interests of the patient.

SEC. 13. Section 1798 of the Health and Safety Code is amended to read:

1798. (a) The medical direction and management of an emergency medical services system shall be under the medical control of the medical director of the local EMS agency. This medical control shall be maintained in the following manner:

(1) Prospectively by written medical policies and procedures to provide standards for patient care.

(2) Immediately by direct voice communication between a certified EMT-P or EMT-II and a base hospital emergency physician or an authorized registered nurse and, in the event of temporary unavailability of voice communications, by utilization by an EMT-P or EMT-II of authorized, written orders and policies established pursuant to Section 1798.4.

(3) Retrospectively by means of medical audit of field care and continuing education.

(b) Medical control shall be within an EMS system which complies with the minimum standards adopted by the authority, and which is established and implemented by the local EMS agency.

(c) In the event a medical director of a base station questions the *medical effect of a policy of a local EMS* agency, the medical director of the base station shall submit a written statement to the medical director of the local EMS agency requesting a review by a panel of medical directors of other base stations. Upon receipt of the request, the medical director of a local EMS agency shall promptly convene a panel of medical directors of base stations to evaluate the written statement. The panel shall be composed of all the medical directors of the base stations in the region, except that the local EMS medical director may limit the panel to five members.

This subdivision shall be operative only until the authority adopts more comprehensive regulations that supersede this subdivision.

SEC. 14. Section 1798.170 of the Health and Safety Code is amended to read:

1798.170. A local EMS agency may develop triage and transfer protocols to facilitate prompt delivery of patients to appropriate designated facilities within and without its area of jurisdiction. Considerations in designating a facility shall include, but shall not be limited to, the following:

(a) A general acute care hospital's consistent ability to provide oncall physicians and services for all emergency patients regardless of ability to pay.

(b) The sufficiency of hospital procedures to ensure that all patients who come to the emergency department are examined and evaluated to determine whether or not an emergency condition exists.

(c) The hospital's compliance with local EMS protocols, guidelines, and transfer agreement requirements.

SEC. 15. Section 1798.172 of the Health and Safety Code is amended to read:

1798.172. (a) The local EMS agency shall establish guidelines and standards for completion and operation of formal transfer agreements between hospitals with varying levels of care in the area of jurisdiction of the local EMS agency, consistent with Sections 1317 to 1317.9a, inclusive, and Section 1798. Each local EMS agency shall solicit and consider public comment in drafting guidelines and standards. These guidelines shall include provision for suggested written agreements for the type of patient, necessary initial care treatments, requirements of interhospital care, and associated logistics for transfer, evaluation, and monitoring of the patient.

(b) Notwithstanding the provisions of subdivision (a), and in addition to the provisions of Section 1317, a general acute care hospital licensed under Chapter 2 (commencing with Section 1250) of Division 2 shall not transfer a person for nonmedical reasons to another health facility unless that other facility receiving the person agrees in advance of the transfer to accept the transfer.

SEC. 16. Section 1798.205 is added to the Health and Safety Code, to read:

1798.205. Any alleged violations of local EMS agency transfer protocols, guidelines, or agreements shall be evaluated by the local EMS agency. If the local EMS agency has concluded that a violation has occurred, it shall take whatever corrective action it deems appropriate within its jurisdiction, including referrals to the district attorney under Sections 1798.206 and 1798.208, and shall notify the State Department of Health Services that a violation of Sections 1317 to 1317.9a, inclusive, has occurred.

SEC. 17. Section 1798.206 of the Health and Safety Code is amended to read:

1798.206. Any person who violates this part, the rules and regulations adopted pursuant thereto, or county ordinances adopted pursuant to this part governing patient transfers, is guilty of a misdemeanor. The Attorney General or the district attorney may prosecute any of these misdemeanors which falls within his or her jurisdiction.

SEC. 18. Section 1798.208 of the Health and Safety Code is amended to read:

1798.208. Whenever any person who has engaged, or is about to engage, in any act or practice which constitutes, or will constitute, a violation of this part, the rules and regulations promulgated pursuant thereto, or local EMS agency protocols, guidelines, or transfer agreements mandated by the state, the superior court in and for the county wherein the acts or practices take place or are about to take place may issue an injunction or other appropriate order restraining that conduct on application of the authority, the Attorney General, or the district attorney of the county. The proceedings under this section shall be governed by Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure, except that no undertaking shall be required.

SEC. 19. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for those costs which may be incurred by a local agency or school district because this act creates a new crime or infraction, changes the definition of a crime or infraction, changes the penalty for a crime or infraction, or eliminates a crime or infraction.

Moreover, no reimbursement shall be made from the State Mandates Claims Fund pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code for other costs mandated by the state pursuant to this act. It is recognized, however, that a local agency or school district may pursue any remedies to obtain reimbursement available to it under Part 7 (commencing with Section 17500) and any other provisions of law for those other costs.

Screening Out the Poor

Could a South Texas Boy's Life Have Been Saved?

By Bill Adler

Zapata

JUST AFTER 4 A.M. on Saturday, December 20, the operator on duty at Starr County Memorial Hospital in Rio Grande City dispatched an ambulance to Roma, 14 miles to the west, in response to a call from a clinic in Ciudad Guerrero, Mexico, a nearby border town. The nurse at the clinic told the dispatcher a young man had a gunshot wound in his head. She said her clinic's ambulance could take the young man as far as Roma, where he could be picked up and delivered to Starr County Memorial, the closest hospital.

The call set off a chain of events over the next eight hours during which at least one hospital — McAllen Medical Center —apparently broke state and federal laws and misused another to avoid economic loss — even while the hospital was aware that a boy who needed the specialized treatment it could provide lay dying on a table in an ill-equipped emergency room only 40 miles away.

While the Rio Grande Valley, with its chronic high unemployment and low tax base, has special problems meeting the health care needs of its poor people, the resolution of the central issue here — serving the public good, versus, in the words of one administrator for a giant hospital chain, "our fiduciary responsibility to our investors" — could have implications for indigent health care nationwide.

THE SIDE OF the road along U.S. Highway 83, which snakes along the river from Rio Grande City to Roma, is covered with dense brush and mesquite. When the Starr County ambulance driver and attendant arrived to make the connection with the Mexican ambulance from Guerrero, they found a tall, skinny 18-year-old with long, black hair and a thin mustache slipping in and out of consciousness. By 6 a.m. the youth, a high school student from Zapata named Carlos Garcia, lay writhing on an emergency room table at the hospital with a bullet lodged in the left side of his brain. Carlos had shot himself behind his right ear while playing with a .22-caliber pistol.

Once the doctors at Starr County Memorial had cleaned the wound, hooked Carlos up to an oxygen tank and intravenous tubes, and taken X-rays, there was little else they could do. They simply lacked the expertise and the facilities at the 44-bed hospital to save Carlos's life. He was now nearly comatose and was bleeding internally. If he were to live, he would need brain surgery immediately. He needed to be transferred to a trauma center — a hospital such as the nearby McAllen Medical Center, which specializes in serious injury cases.

For three hours after Carlos arrived at Starr County Memorial, the nursing supervisor there pleaded with the larger hospitals in the Valley to admit the uninsured boy for surgery. But none would accept him. The closest neurosurgeon available was 40 miles away in McAllen. McAllen Medical Center, the largest of the area hospitals and the one to which Starr County physicians usually refer patients, said no. Why? "They asked me if the patient had any insurance," said Glo Jamandre, the nurse. "When I said no, they told me there were no ICU (Intensive Care Unit) beds available."

Jamandre tried the other hospitals — Rio Grande Regional in McAllen, Valley Baptist in Harlingen, and Brownsville Medical Center, all of which refused to admit Carlos.

Since the adoption of the Texas Constitution in 1876, the responsibility of health care for the state's poor people, or "paupers," has rested with the 254 counties in Texas. But the level of responsibility for the counties was never clearly defined in the Constitution or the courts, and neither was the term "pauper." The state's resulting record of providing health and human services to its indigent population has not been exemplary. (Texas currently ranks 46th in the nation in AFDC and Medicaid funding, according to a recent Children's Defense Fund report.)

After the 1983 session of the Texas Legislature, state leaders appointed a Task Force on Indigent Health Care, chaired by Helen Farabee of Wichita Falls. In its December 1984 report, the task force recommended a package of landmark reforms which the 70th legislature passed in special session in May 1985.

Among the 14 separate pieces of indigent health legislation enacted was an amendment to the Texas Hospital Licensing Law requiring the state Board of Health to adopt rules for the transfer of patients between hospitals. House Bill 1963, the Hospital Transfer Amendments, was intended to outlaw the practice of patient "dumping" — the medically inappropriate transfer, usually from private, for-profit hospitals to public facilities, of critically ill patients who are unable to pay for treatment.

The rules require all licensed hospitals in Texas to transfer patients from physician to physician, as well as from hospital to hospital. But this well-intended law has created a cruelly ironic problem for public hospitals and their indigent patients. It has spawned the new phenomenon of what doctors and administrators in non-profit hospitals call "reverse dumping," whereby uninsured patients are refused admission to private hospitals for economic reasons.

Joel Allison, the chairman of the Texas Association of Public and Non-profit Hospitals, and the administrator of Northwest Texas Hospital in Amarillo, says reverse dumping is "perhaps something that was not anticipated under the transfer act. However, I think we can anticipate it becoming a major issue because the health care system today is so economically driven."

ZAPATA
ROMA
RIO GRANDE CITY
McALLEN
GUERRERO

"Since the transfer act came in," says Dr. Tony Falcon, who has a family practice in Rio Grande City and who is on the staff at Starr County Memorial, "we not only have to get approval from the physician who is going to accept the patient, but we have to get the administrative OK as well. What's happening, and I've seen it happening, is that hospitals are using the law to screen out the non-paying patients."

Bill Adler is a freelance writer living in Austin.

There is a law in Texas which prohibits "wallet biopsies," or discrimination against poor people requiring emergency medical services. The law, enacted in 1983, states, in part: "No officer or employee or member of a general hospital medical staff . . . shall deny emergency services . . . to a person diagnosed by a licensed physician as requiring emergency services because the person is unable to establish his ability to pay for the services. . . ."

The statute carries criminal penalties and could also lead to suspension and/or revocation of a hospital's license, according to Texas Department of Health attorney Susan Steeg. Maurice Shaw, head of TDH's hospital licensing and certification division, told the *Observer* that "in my opinion, McAllen Medical Center violated the law. If they ask about insurance and turn him down, that means they're refusing him because of his inability to pay." McAllen Medical Center administrator John Mims said the decision not to admit Carlos Garcia was not related to his ability to pay but rather was due to a lack of space in the intensive care unit. Shaw said the U.S. Health Care Financing Administration, which oversees Medicare contracts with hospitals, has also indicated to him that McAllen Medical Center "was not in compliance" with Medicare regulations. A spokesman for the federal agency declined to comment on the case. Additional questions have also been raised about whether the hospital violated the federal Hill-Burton program, which provides that a hospital must offer free or low-cost care to poor persons if it received federal funds for construction.

THE GARCIA FAMILY moved to Zapata, a town of 3,500 people about 50 miles south of Laredo, from Ciudad Guerrero when Carlos was 13. Carlos's parents and five brothers and sisters live in a small, tidy house on a corner lot a block off the main highway running through town. Martin Garcia, the father, works as a day laborer when work is to be found. Maria, the mother, is a janitor at the Zapata Health Clinic. Family photos adorn the walls; a framed picture of Carlos — wearing dark sunglasses and a broad smile — and his two-year-old nephew sits atop the television set in the living room.

Carlos's ambitions were modest, his parents said. He wanted to earn enough money to buy himself a car. He liked watching football on television, tinkering with cars, and dancing. It was for a dance Carlos was readying himself on this afternoon, Friday, December 19. There was, after all, reason to celebrate: school had just recessed for the Christmas holidays.

Photo by Marco Garcia

McAllen Medical Center

Carlos had hurried to his cousin's house after school, where he customarily waited for his mother to pick him up after she got off work. This day Carlos asked his mother to stop off on the way home at the dry cleaner's, where he had left a borrowed tuxedo for pressing. On Saturday, he planned to wear it to a friend's quinceanera (sweet 15 party).

But tonight, he and his cousin, also named Carlos, and another friend, were going to a dance hall in Guerrero. They planned to spend the night there at Carlos's grandmother's house. His friends picked up Carlos about 6 on Friday evening, just as Martin Garcia returned home from work. After a couple hours of dancing and drinking, the boys decided to "cruise" downtown Guerrero for awhile. Around midnight, they dropped in for a bite to eat at the house in which Carlos was raised, and which the family still maintains. There Carlos found the pistol, which he and his friends began playing with. A short while later, they left, Carlos still carrying the gun. They arrived at Carlos's grandmother's house around 2, exhausted but in good spirits after a night on the town. The two others went immediately to bed; Carlos, not yet tired enough to sleep, and perhaps enjoying the intoxicating feel of the drink and the gun, again pulled out the weapon. At 3 a.m. his friends were awakened by a single shot.

ON DECEMBER 19, less than 24 hours before Carlos's mishap, McAllen Medical Center had stopped accepting Medicaid and uninsured transfer patients. John Mims, the hospital's administrator, told the McAllen *Monitor* the state and federal governments' "stream-lined" methods of reimbursement for indigent care were to blame for the policy, specifically the revamping in 1983 of Medicare payments coupled with similar, more recent changes in the state-administered Medicaid program. In the past, hospitals were reimbursed by Medicare and Medicaid for each day a patient stayed. The incentive was to keep the patient longer — the longer the stay the more money for the hospital. Now the opposite is true.

Under the Social Security Amendments of 1983, Medicare pays a fixed amount for each patient, based on diagnosis. There are hundreds of categories of illness, known as Diagnosis-Related Groups, or DRGs. Each DRG has an assigned dollar value — like a menu — and each patient is tagged at the hospital door. (In Texas, the Department of Human Services in September instituted a similar Medicaid system, though the fixed amounts are different.) There is no adjustment for severity of illness; pneumonia has a set price, whether the patient stays two days or two weeks. If a hospital can treat the patient for less than the set price, it keeps the extra money. But if the hospital spends too much on treatment, it eats the difference.

By the time Carlos Garcia came knocking with a bullet in his brain, McAllen's Mims had decided he could swallow no more. "Medicaid really messed us up," Mims said. "We take a tremendous loss on transfers and simply cannot take these multi-million dollar hits any more." Mims said the hospital lost $1,087,000 last year on 397 Medicaid and uninsured transfer patients. Even so, Mims acknowledged to the *Observer*, the 339-bed hospital still turned a profit last year for its new owner, Universal Health Services, Inc., of King of Prussia, Pa.

Under fire from physicians throughout the Valley — who complained that the new plan would increase their malpractice insurance rates because it forced them to perform high-risk procedures they formerly farmed out to specialists, and because it denied patients such as Carlos the best care possible — Mims rescinded in the middle of February the no-insurance no-transfer policy.

By mid-morning on Saturday, December 20, two things were apparent to the doctors treating Carlos Garcia in the emergency room of Starr County Memorial Hospital. First, if Carlos were to have any chance of surviving, he needed neurosurgery to relieve the pressure from bleeding in his head. Second, the hospital that could provide the treatment he needed would not voluntarily admit him. It was time to make a decision.

"At that point, it didn't matter what the (transfer) law said or didn't say, because that kid was gonna die on us here," said Dr. Falcon, one of three physicians in the emergency room. He might die in McAllen but he's going to have a better chance over there with the proper specialists and the proper equipment.

"And so the decision we made was to tell the family, 'look, they won't accept you at McAllen if we transfer him, and we can't help you here. Your only chance is for us to release him and for you to request ambulance service to the emergency room at McAllen.' "

At about 11 a.m., with oxygen and IVs still hooked up to him, Carlos was taken by ambulance — with his family following in a station wagon — to McAllen Medical Center. He remained stable on the trip. When he arrived at the emergency room, the hospital had no choice but to admit him.

Carlos was operated on two hours after he arrived in McAllen, but by then had slipped into a coma from which he was never to awake. Four days later Martin Garcia signed a form authorizing the hospital to disconnect his son from the life-support machines. At 11 a.m. on Christmas Eve, Carlos Garcia was pronounced dead. ☐